State of Maine

COMPREHENSIVE HIV PREVENTION PLAN

2004 2008

State of Maine

Comprehensive HIV Prevention Plan

2004 ~ 2008

Maine
HIV Prevention
COMMUNITY
PLANNING GROUP

For additional copies or further information, contact Christine Brooks, Project Coordinator, at the Community Planning Group office:

HIV/CPG
Medical Care Development
11 Parkwood Dr.
Augusta, ME 04330

Phone: (207) 622-7566, ext. 233
TTY: (207) 622-1209
E-mail: mehivcpg@mcd.org

You may also visit the CPG website at: www.mehivcpg.org

Maine HIV Prevention Community Planning Group

CPG CO-CHAIRS

Community Co-Chair
Linda Pfaffinger

Public Health Co-Chair
James Markiewicz

CPG MEMBERS WHO PARTICIPATED IN THE DEVELOPMENT OF THIS PLAN

Danielle Askini
Faith Benedetti
Jean BlackEagle
Noël Bonam
Jordon Bosse
David Brewer
Declan Buckley
John Farrell
Justin Gifford
Linda Hazelton
John Holverson
Gloria Leach
Terrance Mansur
Robert Marsee
Dana Plummer
Geoffrey Pritchard
Mason Smith
Robin Stephens
Scott Tebbetts

CPG MEMBER ADVISORS

Charles Dwyer
HIV/STD Program Manager
Maine Bureau of Health

Joni Foster
HIV Education Coordinator
Maine Department of Education

Jarad Platt
Substance Abuse Treatment Specialist
Maine Office of Substance Abuse

Additional Advisors to the CPG

Mark Griswold
HIV/AIDS Epidemiologist
Maine Bureau of Health

Ken Town
Ryan White Title II Program Coordinator
Evaluation Specialist II
Muskie School of Public Service
University of Southern Maine

CPG PROJECT COORDINATOR

Christine Agronick Brooks

Dedication:

This Plan is dedicated to CPG members who have participated in HIV prevention planning through the years and have since passed away. The CPG wishes to acknowledge the contributions that they have made. A special dedication to:

Jody Lee Hartley
Dana McKeen
Alexis Parretti
Ann Sachs

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Chapter 1
INTRODUCTION

The Maine HIV Prevention Community Planning Group (CPG) proudly presents the 2004 – 2008 *Comprehensive HIV Prevention Plan*. The Plan informs the Maine Bureau of Health's HIV/STD Program, and other stakeholders involved in HIV prevention efforts, of the CPG's recommendations for HIV prevention services. This stand-alone document supplants the *2001 Maine Comprehensive HIV Prevention Plan*, and the subsequent *June 2003 Update*.

GOALS FOR HIV PREVENTION

The State of Maine Bureau of Health has two HIV prevention goals for all HIV prevention activities. These are:

Goal 1. The health of all Maine people will be improved by promoting behaviors, attitudes, community building and/or knowledge that reduce the risk of HIV.

Goal 2. HIV-infected persons in Maine will have reduced morbidity and mortality through increased access to early medical and related-service intervention.

In order to accomplish these HIV prevention goals, the Bureau of Health uses the information contained in this HIV Prevention Plan in making funding decisions and for purchasing HIV prevention programs. The Plan provides information about the characteristics of the populations prioritized for HIV prevention and includes information about the types of interventions that would best address their needs.

HIV PREVENTION PLAN OVERVIEW

The priority populations, needs, and interventions included in this Plan are the result of a prioritization process undertaken by CPG members. CPG members are individuals who come from Maine communities most affected by the HIV epidemic and they bring a wealth of personal knowledge and experience to the planning process. This knowledge of community norms and values is combined with an examination of behavioral science data about effective HIV prevention techniques, and the study of local and national HIV/AIDS epidemiological data in order to formulate the recommendations included in this Plan.

CPG members reviewed an enormous amount of data in order to write this Plan including HIV and STD epi data (2003 Epi Profile, Maine BOH) hepatitis C data; and the Community Services Assessment (CSA). See page 10 for more information about the CSA. Note that the Epi Profile and the CSA are available as separate documents from the Bureau of Health, HIV/STD Program.

HIGHLIGHTS OF THIS HIV PREVENTION PLAN:

- The first priority population in this Plan is People who are HIV+. See Chapters 3 and 4 for more information.

- In keeping with the CDC's Advancing HIV Prevention Initiative, the CPG has adopted the CDC's Serostatus Approach to Fighting the Epidemic (SAFE) model as a basis for prevention activities in the State. See Chapters 3 and 5 for information on this model and how to implement it. If you would like more information on the Advancing HIV Prevention Initiative visit the CDC website: http://www.cdc.gov/hiv/partners/ahp.htm.

- Prevention activities and interventions for the behavioral populations now include a distinction between people at "high risk," and people at "very high risk" of infection. See Chapter 5 for details.

- The CPG has developed new recommendations for Counseling, Testing and Referral (CTR). See Chapter 5, page 44 for details.

- The CPG recommends that the Bureau of Health develops a cross-disciplinary work group to address overall systems needs in Maine. See page 34 for information on systems needs and specific recommendations.

- Three behaviorally based populations remain at risk for HIV in Maine and they have been prioritized throughout the State as follows:
    - Males who have Unsafe Sex with Males (MSM)
    - Injection Drug Users who Share Needles and Injection Equipment (IDU)
    - Heterosexual Females who have Unsafe Sex (HET)

  See Chapters 3 and 4 for more information about these prioritized populations.

- As in the 2003 Update, three regions were used to divide the State geographically, however in this Plan they have been prioritized in the following order:
    - Southern: York and Cumberland Counties
    - Central: Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset and Waldo Counties
    - Northern: Aroostook, Hancock, Penobscot, Piscataquis and Washington Counties

  See Chapter 3 for more information on these regional priorities.

- The CPG recognizes there are populations that have characteristics requiring special prevention strategies and cultural competencies. These populations may include the deaf community, youth, people who are transgendered and

people who have a mental illness or other disability and/or who are homeless or incarcerated, or are members of racial and ethnic minorities, etc. Chapter 7 contains revised, updated information about these populations.

- Information on criteria for effective interventions and prevention programs can be found in Chapter 6. This Chapter also includes an overview of various behavioral and social science theories and their use in HIV prevention planning.

It is the charge of the CPG, after reviewing the epi data and trends, to determine where to focus HIV prevention services to prevent as many new infections as possible given the limited federal funding available. It is our hope that this Plan will help to accomplish this. The CPG acknowledges that this does not diminish the needs of other populations in Maine and encourages efforts to find increased funding to serve these populations.

Chapter 2
THE COMMUNITY PLANNING PROCESS

This Chapter provides a summary of the overall goals and objectives of community planning as well as specifics about process used to develop this Plan.

HISTORY AND PURPOSE OF COMMUNITY PLANNING

Community planning began in 1993 when the Centers for Disease Control and Prevention (CDC) directed states and other jurisdictions that receive CDC funding for HIV prevention to begin a community process for HIV prevention. The intent of the process was threefold: to increase meaningful community involvement in prevention planning, to improve the scientific basis of program decisions, and to target resources to those communities at highest risk for HIV transmission/acquisition.

Maine has one statewide planning group. The purpose of the Maine HIV Prevention Community Planning Group (CPG) is to write and update the *State of Maine Comprehensive HIV Prevention Plan.* The CPG uses the most recent information about HIV, trends, information about who is infected in Maine and information about interventions that work to change peoples' behavior, to decide the most important ways to prevent the spread of HIV. The CPG is charged with developing a comprehensive plan in which populations are prioritized and interventions are chosen based on their ability to prevent as many new infections as possible.

The CPG works in collaboration with the Bureau of Health to develop this Plan. To make sure that the Plan includes the norms and values of the community, the CPG tries to recruit many different kinds of members to reflect the different groups that are affected by HIV in Maine. In this way, populations that carry the largest burden of HIV infection are an integral part of the planning process. Community members, health care providers and health scientists all work together to understand the epidemic in Maine and come up with the best ways to prevent new infections. This is an ongoing process intended to improve the effectiveness of HIV prevention programs funded by the Bureau of Health.

Goals and Objectives of Community Planning as Defined by the CDC

- **Goal One:**
  Community planning supports broad-based community participation in HIV prevention planning.
  - **Objective A:** Implement an open recruitment process (outreach, nominations, and selection) for CPG membership.

  - **Objective B:** Ensure that the CPG membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.
  - **Objective C:** Foster a community planning process that encourages inclusion and parity among community planning members.

- **Goal Two:**
  Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.
  - **Objective D:** Carry out a logical, evidence-based process to determine the highest priority, population-specific prevention needs in the jurisdiction.
  - **Objective E:** Ensure that prioritized target populations are based on an epidemiologic profile and a community services assessment.
  - **Objective F:** Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.

- **Goal Three:**
  Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan.
  - **Objective G:** Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.
  - **Objective H:** Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.

THE MAINE HIV PREVENTION COMMUNITY PLANNING GROUP

According to its current Bylaws, the CPG consists of no less than eighteen (18) and no more than thirty (30) voting members. Membership slots are proportional to the epidemic in Maine. In this way, populations that carry the largest burden of HIV infection have the most representation on the CPG. These voting members participate in the community planning process as a representative and a voice for the populations at high risk for HIV infection.

In addition the CPG has membership slots for Member Advisors. As nonvoting members, these Advisors can represent: state health departments; state education

agencies; other relevant agencies (e.g. substance abuse, mental health, corrections); or they may have expertise not otherwise represented on the group such as Epidemiology. They share relevant information with the CPG and disseminate information about HIV prevention and the *HIV Prevention Plan* priorities to their agencies in order to increase the collaboration and coordination of the various prevention, care and treatment efforts in the State. The CPG currently has Member Advisors from the:

- Bureau of Health HIV/STD Program
- Maine Department of Education
- Office of Substance Abuse

Membership applications for Community Representatives and Member Advisors are available from the CPG office. Completed application packets, including reference checks, are reviewed by the Membership Committee; population gaps are assessed; and recommendations are presented to the full CPG membership at the next monthly meeting. Selection of new members to fill vacancies is made by consensus. Voting members serve a minimum of one (1), one-year term, beginning on the date of the first meeting attended and may serve a maximum of five consecutive one-year terms before having to undergo a reapplication process.

Voting members are representatives of an at-risk behavioral population and represent one of the three (3) regions of the State. Members are required to attend one full day meeting per month and meet in Behavioral Population and Regional Committees during these monthly meetings. All prioritization decisions are made during the monthly meetings.

Members also participate in additional sub-committees as interest and time allows. Sub-committee work is brought back to the full group where final decisions are made through a modified consensus decision-making process. Sub-committees in effect during this planning process include the:

- Executive Committee
- Membership Committee
- Analysis Information and Data (AID) Committee
- Revise/Rewrite Committee
- HIV+ Needs and Interventions Committee
- MSM, IDU and HET Behavioral Population Committees

The CPG also has a representative serving on the HIV Advisory Committee and the Ryan White Advisory Committee.

In order to ensure parity among members of this diverse group, training and technical assistance was provided by the Executive Committee, the Co-Chairs and the Coordinator during all phases of the planning process. This facilitates members' understanding of the work of the group and enables them to participate fully in the decision making process. Additional technical assistance is requested from the CDC as needed.

The CPG membership profile during this planning process was as follows:

CPG MEMBERSHIP REPRESENTATION

February 2004

Primary Prioritized Population Groups	Current Members	Gender	Regional Representation
Males who have Unsafe Sex with Males (MSM)	11	10 – Male 1 – Trans W	**Northern:** 2 **Central:** 3 **Southern:** 6
Injection Drug Users who Share Needles and Injection Equipment (IDU)	6	2 - Male 3- Female 1 – Trans M	**Northern:** 1 **Central:** 4 **Southern:** 1
Heterosexuals who have Unsafe Sex (HET)	4	3 – Female 1 – Male	**Northern:** 3 **Central:** 1 **Southern:** 0
TOTAL <u>voting</u> members	21	13-M, 6-F, 2-Transgender	**Northern:** 6 **Central:** 8 **Southern:** 7

Race		Expertise		HIV+
African American/Black Asian Pacific Islander Native American More than one race	 1 1 	Community Representative Behavioral/Social Scientist Epidemiologist Evaluation Researcher Intervention Specialist Health Planner	21 6 1 (non-member advisor) 2 (1 a non-member advisor) 7 6	33% of total members

CPG MEMBER ADVISORS Non-voting members	
Bureau of Health, HIV/STD Program	1
Maine Department of Education	1
Maine Office of Substance Abuse	1

Chapter 3
PRIORITIZATION

The term "Prioritized Populations" is used to describe groups of individuals whose behaviors put them at high risk for HIV infection, and thus are most in need of HIV prevention services. Priority setting is a very difficult process as the amount of money available for prevention is not enough to provide HIV prevention programs to meet all the needs of the populations at-risk identified by the CPG. Before beginning, the CPG clarified roles and responsibilities, reviewed its decision-making process, and provided ongoing training to members covering all aspects of the prioritization process. This Chapter reviews how priorities were set and the prioritized target populations and regional priorities that resulted.

THE PRIORITY SETTING PROCESS

The priority setting process was undertaken by the entire Community Planning Group (CPG). All voting CPG members (both HIV+ and negative) represent a prioritized behavioral population and one of the three (3) regions of the State. Members participated in corresponding committees that reviewed pertinent data and then set the priorities laid out in this HIV Prevention Plan. The three (3) behavioral populations are: Males who have Unsafe Sex with Males (MSM), Injection Drug Users who Share Needles and Injection Equipment (IDU), and Heterosexuals who have Unsafe Sex (HET).

The development of this HIV Prevention Plan was conducted both at monthly CPG meetings and supplementary subcommittee meetings between October 2003 and May 2004. Due to the low incidence and prevalence of HIV/AIDS in Maine the Executive Committee decided to adopt a process that involved data review and discussion by CPG members using a modified consensus decision-making process. This process identified target populations, their prevention needs, and the interventions that would be most effective for these individuals.

CPG members, in their respective Behavioral Population and Regional Committees, reviewed the following sources of information in making their decisions. Unless otherwise noted, these documents are available from the Maine Bureau or Health, HIV/STD Program at (207) 287-3747.

- **Epi Profile** Produced by the Bureau of Health (BOH), HIV/STD Program. It describes how HIV/AIDS affects people living in Maine including: which populations, age groups and ethnic groups are affected by HIV in a defined area; HIV and STD incidence and rates; etc.
- **Hepatitis C data** General information on hepatitis A, B and C and recommendations for HIV prevention planning was provided by the Bureau of Health Integrated Hepatitis Coordinator, (207) 287-3817.

Community Services Assessment (CSA) The CSA includes Needs Assessments, a Resource Inventory and a Gap Analysis. The following documents are included in the CSA and were reviewed by the CPG:

- **2002-2003 Needs Assessment:** Produced by the CPG and the BOH. This document provides information on the knowledge, attitudes, beliefs and behaviors of people at risk through sexual contact.
- **HIV Prevention and Injection Drug Use in Maine A Statewide Needs Assessment** Produced by the BOH HIV/STD Program, it provides an assessment of the HIV prevention needs of IDUs in Maine.
- **Resource Inventory** Produced by the CPG, the Maine AIDS Alliance, and the BOH it provides information on current HIV prevention related resources, activities and services throughout the State regardless of funding source.
- **Gap Analysis** Provides a description of the unmet HIV prevention needs of the populations at high risk that were identified in the Epi Profile. The unmet needs are identified by comparing the needs of the populations (as indicated in the Needs Assessment) to the services available (as listed in the Resource Inventory).

- **Transgender Behavioral Risk Assessment** This survey was conducted by the CPG in 2003. Preliminary results of this survey were reviewed. For further information contact the CPG office (207) 622-7566, ext. 233.
- **Behavioral Surveillance 2003: Men Who Have Sex with Men in Maine** Compiled by the BOH HIV/STD Program to gather more information related to the increase in HIV and STD's among MSM.
- **Ryan White Title II case management data** Information, including the Coordinated Statement of Need, was provided by the Ryan White Title II Program Coordinator at the BOH.
- **Youth Risk Behavior Survey (YRBS)** Provides information about adolescent health-risk behaviors and prevention indicators. For more information contact the HIV Education Coordinator at the Maine Department of Education (207) 624-6687.
- **May 2003 Update to the *HIV Prevention Plan*** The CPG reviewed the previous priorities. Contact the CPG office at (207) 622-7566, ext 233 for more information.
- **The Compendium of HIV Prevention Interventions with Evidence of Effectiveness** from the CDC. Available on the web at: http://www.cdc.gov/hiv/pubs/hivcompendium/HIVcompendium.pdf
- **Procedural Guidance for Selected Strategies and Interventions for Community Based Organizations Funded Under Program Announcement 04064** from the CDC which contains information on targeted outreach and prevention interventions. Available on the web at: http://www2a.cdc.gov/hivpra/pa04064_cbo.html

The CPG also reviewed the Centers for Disease Control and Prevention's (CDC) *Advancing HIV Prevention: New Strategies for a Changing Epidemic* (http://www.cdc.gov/hiv/partners/ahp.htm). This initiative was announced in April

2003 and it focuses on reducing barriers to early diagnosis; improving referral to prevention services, medical care, and treatment; and ensuring that prevention programs are in place to assist people living with HIV.

As part of the priority setting process, the CPG decided to adopt the *Serostatus Approach to Fighting the Epidemic (SAFE)*. This is a CDC strategy for HIV prevention. The CPG felt with limited resources, adopting the basic components of this initiative would be an effective shift for HIV prevention in the State and follow the *Advancing HIV Prevention* initiative. The SAFE model is designed to complement existing HIV prevention activities. It requires activities be focused on recruitment into Counseling, Testing and Referral services (CTR) and to addressing the needs of very high-risk negative and HIV positive people.

Using the SAFE model, the CPG identified activities, services and interventions that would facilitate recruitment for testing, assess risk, and address the HIV prevention needs of HIV positive people and those at very high risk of infection. The goal of these interventions is to support the adoption and maintenance of HIV risk reduction behaviors among very high-risk members of the behavioral populations and HIV positive people.

The CPG, working in three Behavioral Population Committees (MSM, IDU, HET), also identified critical needs for the populations through review of needs assessment data and other community input. Note that the needs detailed in this Plan are not inclusive of all the needs of the populations, or the individuals within each population, and are not listed in priority order.

All decisions were made in Population and Regional Committees and included justifications for choices made. Each Committee had the opportunity to review and comment on choices made by the other. The full CPG reviewed the final draft of this Plan and approved it by consensus.

HIV PREVENTION PRIORITIES ~ Target Populations

As a result of the priority setting process the CPG decided on the following prioritized target populations for all three (3) regions in Maine. These behavioral populations are listed in priority order. The justifications used in determining the priorities are also included.

PRIORITIZED TARGET POPULATIONS: Southern, Central and Northern Regions of Maine

Rank	Behavior	Gender	Race/Ethnicity	HIV Status
1.	MSM, IDU, HET	Male, Female, Transgender	All	Positive
2.	MSM	Male, Transgender	Caucasian/White African American/Black Latino/Latina/ Hispanic Native American	Unknown or negative
3.	IDU	Male, Female, Transgender	Caucasian/White African American/Black Latino/Latina/ Hispanic Native American	Unknown or negative
4.	HET	Female, Transgender	Caucasian/White African American/Black Latino/Latina/ Hispanic Native American	Unknown or negative

MSM = Males who have Unsafe Sex with Males
IDU = Injection Drug Users who Share Needles and Injection Equipment
HET = Heterosexuals who have Unsafe Sex

JUSTIFICATION FOR PRIORITIZATION

The CPG reviewed all of the data listed at the beginning of this Chapter in making its decisions. In particular, the following information from the CPG prioritization process helped to inform the final decisions:

- The epi data provided by the Bureau of Health (BOH) clearly shows that MSM continue to carry the burden of HIV infection in Maine (67% of cases in 2003) and that, in fact, there has been an increase in the number of new infections in this population over previous years. MSM also have increased rates of

gonorrhea and syphilis according to the STD data provided by the BOH. These rates have increased in 2003 and remained high in the first quarter of 2004. BOH epi data also notes that in 2003 HIV diagnoses where infection appeared to have occurred in the last 18 months, 22 of the 24 infections were among MSM.

- According to the Epi Profile, both MSM and IDU are disproportionately affected by HIV in Maine when compared to the estimated overall number of MSM and IDU living in the State. Of those infected, MSM accounted for 67% of cases in 2003, IDU comprised 15%, and heterosexual transmission with a known at-risk partner accounted for 7% of cases (2003 Epi Profile, BOH). This led to the prioritization of MSM, IDU and HET (in that order) for all regions of the State.

- According to the Epi Profile (BOH, 2003) in 2003 69% of people infected with HIV were 30 and over, and 31% were under 30. Concurrent diagnosis of HIV and AIDS continues to be a major issue comprising almost half of the new diagnoses (45% over the past 5 years according to the BOH Epi Profile). Therefore, many people are waiting until they become ill before they test and were likely infected years before being diagnosed. In addition, the proportion of people under 30 who became infected almost doubled during 2003 from the proportion seen previously between 1999 – 2002 (2003 Epi Profile). This led to the decision by the CPG to eliminate age categories in this Plan and put the focus on CTR outreach using the SAFE model.

- African Americans/Blacks, Latinos/Latinas/Hispanics, and Native Americans have a low incidence of HIV but continue to have disproportionate rates of infection according to the epi data. The non-White and Hispanic population of Maine comprises approximately 3% of the state's total population (2000 Census), but 17% of people diagnosed during the past five years were from racial/ethnic minority groups (2003 BOH Epi Profile). Most prominently represented among these groups were African-American/Blacks, comprising 10% of total diagnoses. In addition, in 2003 People of Color comprised 22% of the new diagnoses. These populations were therefore included in Plan priorities for culturally competent services.

HIV PREVENTION PRIORITIES ~ Regional Priorities

The CPG also reviewed regional data in order to determine prevention priorities. The regional priorities as decided on by the CPG are listed below followed by pertinent information from the 2000 Census for each of these three regions of the State.

REGIONAL PRIORITIES

Following review of the epi data and trends in the epidemic, the CPG recommends the following priority be given to the three regions of the State for prevention activities:

Rank	Region	Counties
1.	SOUTHERN	Cumberland and York Counties
2.	CENTRAL	Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset and Waldo Counties
3.	NORTHERN	Aroostook, Hancock, Penobscot, Piscataquis and Washington Counties

- **As a result of this prioritization, the greatest allocation of HIV prevention resources should occur in the Southern Region of Maine which is disproportionately affected by HIV (2003 Epi Profile, Maine BOH).**

SOUTHERN MAINE REGIONAL DESCRIPTION:

Counties in Southern Maine: Cumberland and York

Some Pertinent Regional Facts from the US Census and State Government websites are as follows**:**

	Cumberland	York
Land area	836 square miles	991 square miles
Cities	Portland (metropolitan area), South Portland, Westbrook	Biddeford, Saco
2001 population estimate	266,988	192,704
Persons per square mile 2000	317.9	188.5
Persons under 18	23.3%	24.8%
Persons 65 and over	13.3%	13.6%
White persons in 2000	95.7%	97.6%
Other races or Hispanic ethnicity over 1%	Black/African Am: 1.1%, Asian: 1.4%, 2 or more races: 1.1%, Hispanic: 1%	None
Below poverty in 1999	7.9%	8.2%

CENTRAL MAINE REGIONAL DESCRIPTION:

Counties in Central Maine: Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset and Waldo Counties

Some Pertinent Regional Facts from the US Census and State Government websites are as follows**:**

	Androscoggin	Franklin	Kennebec	Knox	Lincoln	Oxford	Sagadahoc	Somerset	Waldo
Land area	470 square miles	1,698 square miles	868 square miles	366 square miles	456 square miles	2,078 square miles	254 square miles	3,926 square miles	730 square miles
Cities	Lewiston/Auburn (metropolitan area)	None, County Seat – Franklin	Augusta, Gardiner, Hallowell, Waterville	Rockland	None, County Seat – Wiscassett	None, County Seat – Paris	Bath	None, County Seat – Skowhegan	Belfast
2001 population estimate	104,131	29,586	117,782	40,147	34,316	55,378	35,761	51,014	37,252
Persons per square mile 2000	220.7	17.4	135	108.3	73.7	26.3	138.7	13	49.7
Persons under 18	23.9%	23.5%	23.8%	22.4%	22.7%	24.2%	25.8%	24.7%	24.2%
Persons 65 and over	14.4%	14.2%	14.2%	17.2%	18.2%	16.1%	12.3%	14.3%	13.6%
White persons in 2000	97%	98%	97.5%	98.3%	98.5%	98.3%	96.5%	98%	97.9%
Other races or Hispanic ethnicity over 1%	Hispanic: 1%, 2 or more races: 1.2%	None	2 or more races: 1%	None	None	None	Hispanic: 1.1%, 2 or more races: 1.2%	None	2 or more races: 1.1%
Below poverty in 1999	11.1%	14.6%	11.1%	10.1%	10.1%	11.8%	8.6%	14.9%	13.9%

NORTHERN MAINE REGIONAL DESCRIPTION:

Counties in Northern Maine: Aroostook, Hancock, Penobscot, Piscataquis, Washington

Some Pertinent Regional Facts from the US Census and State Government websites are as follows**:**

	Aroostook	Hancock	Penobscot	Piscataquis	Washington
Land area	6,672 square miles	1,588 square miles	3,396 square miles	3,966 square miles	2,568 square miles
Cities	Caribou, Presque Isle	Ellsworth	Bangor (metropolitan area), Brewer, Old Town	None, County Seat - Dover-Foxcroft	Calais, Eastport
2001 population estimate	73,140	52,336	145,385	17,177	33,573
Persons per square mile 2000	11.1	32.6	42.7	4.3	13.2
Persons under 18	22.3%	22.3%	22.8%	23.4%	22.9%
Persons 65 and over	17%	16%	13.1%	17.4%	17.3%
White persons in 2000	96.6%	97.6%	96.6%	97.8%	93.5%
Other races or Hispanic ethnicity over 1%	Native Americans/Alaskan Native: 1.4%	2 or more races: 1.1%	Native Am/Alaskan Native: 1%, 2 or more races: 1%	2 or more races: 1%	Native Am/Alaskan Native: 4.4%, 2 or more races: 1.1%
Below poverty in 1999	14.3%	10.2%	13.7%	14.8%	19%

Chapter 4
ABOUT THE TARGET POPULATIONS: Descriptions, Factors Affecting Risk, Critical Needs

This Chapter provides a description of each of the target populations listed in Chapter 3. It also lists the factors contributing to risk in each of the four priority populations, as well as their critical needs. The last section discusses overarching statewide systems needs that affect all of the target populations.

PRIORITY 1: People Who Are HIV+

BEHAVIORAL POPULATION DESCRIPTION

Every new HIV infection involves an HIV+ person. An estimated 850,000 to 950,000 people are living with HIV in the United States, and an estimated 1,200 people with HIV/AIDS live in Maine (BOH, 2003). This figure includes the estimated number of people who are HIV+ but have not yet been tested. The Centers for Disease Control estimates that approximately one-third to one-fourth of people living with HIV are not aware of their HIV infection. Of the 1,200 people living with HIV/AIDS in Maine, 575 were served during 2003 by one of the 6 Ryan White Title II case management agencies.

In the past few years, advances in treatment and care for HIV+ persons have helped many people enjoy increased health and longer life. For many, this allows for a renewed interest in sexual and, for some, drug-using activity. More sexually active and drug-using HIV+ persons mean the possibility of more new infections. People who are HIV+ need to have access to interventions to help them stay safe, and to play an active role in stopping the epidemic.

In the past, prevention efforts had not been directed toward HIV+ persons for fear of "pointing the finger" or blaming HIV+ persons for the epidemic. Although HIV/AIDS has become less stigmatized in the US, in some communities there is still serious stigma experienced by HIV+ persons. AIDS activists and HIV+ persons have also feared laws criminalizing sexual risk behaviors and further criminal prosecution of injection drug users.

HIV+ persons are unique in that they require both prevention and care services, requiring effective coordination and integration of HIV prevention and care programs. A new HIV diagnosis can provide strong motivation for an individual to change behaviors, allowing care providers an important opportunity to educate clients about HIV prevention. For HIV prevention educators, the prevention needs and care issues of people living with HIV need to be specifically addressed.

HIV prevention services for HIV+ people should also engage their partners through Partner Counseling and Referral Services (PCRS) and offer them Counseling, Testing and Referral (CTR). These partners, through behavioral characteristics, may be at risk for HIV infection.

It is important to note that not all people who are HIV+ are in need of prevention services. Prevention services should focus on those who engage in unsafe sex (particularly with a serodiscordant partner) and/or share injection equipment thereby putting themselves and others at risk for HIV infection or re-infection.

BEHAVIORAL CHARACTERISTICS: People who are HIV+

Certain behaviors may increase the level of risk for this population and are indications that intensive, individualized HIV prevention services may be required. The following behaviors are <u>not</u> listed in order of priority:

- Engaging in unprotected sex
- Exchanging unprotected sex for money, goods, and/or survival needs
- Sharing needles and/or injection equipment
- Using or abusing drugs and alcohol

FACTORS AFFECTING THE ADOPTION AND MAINTENANCE OF HIV RISK REDUCTION BEHAVIOR: People Who Are HIV+

- Knowledge of status
- Mental health issues including: fear, anger, loneliness, depression, self esteem, sexual compulsion, past trauma issues, stress, and coping difficulties
- Dual diagnosis (HIV combined with substance abuse, a mental illness, etc.)
- Difficulty maintaining safer sex practices over time
- Disclosure difficulties
- Stigma
- Lack of support
- Education about the disease and treatment options

CRITICAL NEEDS: People who are HIV+

Based on review of needs assessment data and member expertise, the following is a list of critical needs that exist for this population. These needs are directly related to the factors that affect risk mentioned above and may be useful in designing interventions. They are not listed in order of priority.

- Increase testing through Counseling, Testing and Referral (CTR) which includes Partner Counseling and Referral Services and anonymous CTR.
- Increase skills related to problem solving, stress management and communication including disclosure of HIV status.
- Increase awareness of obstacles to safer behavior including self esteem, dual diagnosis, adherence to all medication regimes, trauma issues, loneliness and anger.
- Increase knowledge of the disease and treatment options.
- Increase norms for having clean needles and using them.
- Provide STD and viral hepatitis information to this population.
- Provide risk assessment, testing, vaccination and referrals for STD's and all types of hepatitis as appropriate.

CRITICAL SYSTEM NEEDS: People who are HIV+

In addition to the specific needs listed above for people who are HIV+, there are broad systems needs that are the responsibility of different programs and agencies within the State that are important for this population. The CPG feels that is critical that these needs be met in order for HIV prevention to occur. It is important to create better links between prevention and other types of care (e.g. case management, substance abuse treatment, mental health treatment, etc.). The CPG encourages collaboration and cooperation between agencies, funders and providers to ensure that these needs are addressed. The following system needs were identified by the CPG for people who are HIV+ and are not listed in order of priority.

- Increase access and availability of clean needles and increase the number of needles that can be obtained at one time.
- Increase training for prevention and care staff about people living with HIV, including their fears, as well as ways to make their services more user friendly and welcoming.
- Increase risk assessment training of, and coordination with, referral resources.
- Increase immediate, facilitated referrals to needed resources and services including to AIDS Service Organizations (ASO's).

- Develop and implement Standards of Care for Case Management services.
- Institute ongoing ethics training for all prevention and care staff.

ADDITIONAL RESOURCES: People Who Are HIV+

Center for AIDS Prevention Studies at the University of California San Francisco, "Fact Sheet 37E: What are HIV+ Persons' HIV Prevention Needs?" available on the web at: http://www.caps.ucsf.edu/capsweb/

National Association for People With AIDS (NAPWA), 1413 K Street, NW, 7th Floor, Washington, DC 20005; phone: (202) 898-0414; fax: (202) 898-0435; e-mail: napwa@napwa.org

Maine Bureau of Health HIV/STD Program (administers Ryan White Title II funding in Maine); Contact the Ryan White Title II Coordinator, State House Station 11, Key Bank Plaza, 9th Floor, Augusta, ME 04333; phone: (202) 287-5551.

PRIORITY 2: Males who have Unsafe Sex with Males (MSM)

BEHAVIORAL POPULATION DESCRIPTION

Males who have Unsafe Sex with Males are not a single homogenous group. They represent a wide variety of men (both young and adult males from different races, socioeconomic backgrounds and gender identities) with diverse health, and social needs. Males who have unsafe sex with males are at risk for acquiring or transmitting HIV because of the unsafe sexual behaviors they engage in, not because of how they identify themselves. Anecdotal information indicates that Gay-identified males make up the majority of infections in Maine and should be the main focus of prevention activities for MSM.

For males who have unsafe sex with HIV+ males, unprotected receptive anal intercourse remains the greatest risk for HIV transmission. HIV is transmitted from an HIV positive man to an HIV negative man through infected bodily fluids, including blood, semen, and pre-ejaculate fluid.

The reality of HIV is woven into the physical, psychological, emotional, and social aspects of men's lives including dating and intimacy, sexual desire and love, abuse and coercion, alcohol and recreational drug use, racism, classism, heterosexism, homophobia, transphobia, as well as individual self-esteem. HIV prevention programs must acknowledge all of these elements.

BEHAVIORAL CHARACTERISTICS: MSM

Certain behaviors may increase the level of risk for this population, including the following, which are <u>not</u> listed in order of priority:

- Having unsafe sex with multiple partners
- Having multiple unsafe sexual encounters
- Sharing needles and injection equipment
- Using alcohol and recreational drugs including cocaine and methamphetamines and also engaging in unprotected sex
- Exchanging sex for money (as in sex work or prostitution), and/or goods and/or services (e.g. lodging, food, clothing etc.)
- Having unsafe sex with a partner of unknown sero-status
- Having a sexual addiction or compulsive need to have sex
- Having sex with an HIV+ partner

FACTORS THAT MAY AFFECT THE ADOPTION AND MAINTENANCE OF HIV RISK REDUCTION BEHAVIOR: MSM

- Enjoying unprotected sex better and feeling that condoms decrease pleasure.
- Perception that HIV is not a big deal ~ low level of concern about getting HIV or other STDs.
- Mental and physical health issues such as self-esteem, history of trauma/abuse, loneliness and addictions (drugs, alcohol, sexual compulsivity, etc.).
- Social, cultural issues including homophobia, oppression, and lack of positive social and environmental structures, community norms and role models.

CRITICAL NEEDS: MSM

Based on review of needs assessment data and member expertise, the following is a list of critical needs that exist for this population. These needs are directly related to the factors that affect risk mentioned above and may be useful in designing interventions. They are <u>not</u> listed in order of priority.

- Increase the perception and acceptability of safe sex as the norm.
- Increase the perception that safe sex is erotic.
- Increase the motivation, intention and commitment to reduce high risk behaviors.
- Increase use of risk reduction practices including reducing the number of sexual encounters and number of partners.
- Increase the variety and availability of safer sex supplies.
- Increase the use of partner communication skills that reduce HIV transmission including safer sex, refusal skills, and disclosure of HIV status.
- Increase use of problem solving, coping and decision making skills that reduce HIV transmission.
- Increase knowledge that HIV/AIDS is a fatal disease existing in Maine, and that there are complications and quality of life problems resulting from infection and medications.
- Increase belief that acquiring HIV/AIDS is undesirable.
- Increase awareness of personal risk.
- Increase awareness of mental and physical health issues (such as self-esteem, history of trauma/abuse, loneliness, etc.) and addictions (such as drugs, alcohol, sexual compulsivity, etc.) as obstacles to practicing safer sex.
- Increase knowledge of status through low barrier, peer led, targeted outreach CTR to venues including gay bars.

- Increase the use of targeted outreach on the Internet.
- Recommend that STD and hepatitis messages be included during outreach to this population.
- Refer MSM for hepatitis A/B vaccine.
- Provide risk assessment and referral for hepatitis C testing as appropriate.

CRITICAL SYSTEM NEEDS: MSM

In addition to the specific needs listed above for MSM, there are broad systems needs that are the responsibility of different programs and agencies within the State that are important for this population. The CPG feels that is critical that these needs be met in order for HIV prevention to occur. The CPG encourages collaboration and cooperation between agencies, funders and providers to ensure that these needs are addressed. The following system needs were identified by the CPG for MSM and are <u>not</u> listed in order of priority.

- Increase access to affordable, culturally competent substance abuse and mental health treatment and medical care providers.
- Increase diffusion of culturally competent messages.
- Advocate for environmental/structural changes that would decrease discrimination and stigmatization.
- Advocate for changes in the media portrayal of unsafe sex.

ADDITIONAL RESOURCES: MSM

Carnes, P., & Delmonico, D. (Eds.). (2001). Special issue: HIV and sexual compulsivity. *Sexual Addiction & Compulsivity,* 12(2).

Kelley, J. (1995). *Changing HIV risk behavior: Practical strategies.* Guilford Press, New York.

Real, T. (1997). Don't want to talk about it: Overcoming the secret legacy of male depression. New York NY: Scribner.

Trussler, T., Marchand, R. (1997). Field guide community HIV health promotion. Vancouver, BC: AIDS Vancouver/Health Canada.

van der Kolk, B.A., (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry, 1,* 253-265.

van der Kolk, B.A. & van der Hart, O. (1991). The intrusive past: The flexibility of memory and the engraving of trauma. *American Imago,* 48(4), 425-454.

PRIORITY 3: Injection Drug Users who Share Needles or Injection Equipment (IDU)

BEHAVIORAL POPULATION DESCRIPTION: IDU

According to epidemiological data the number of injection drug users (IDU) or people with histories of injection drug use who have tested positive for HIV or have AIDS has remained relatively stable. However, the higher quality and lower price of injection drugs coupled with increased availability contributes to a rise in the number of people who use injection drugs. According to the Maine Office of Substance Abuse (OSA June, 2003 Treatment Data System) the total number of admissions for persons seeking treatment for heroin addiction as their primary drug of choice has gone up from 383 in 1995, to 1,468 in 2003. Likewise, the total number of admissions for treatment of other opiates and synthetics has gone up from 231 in 1995, to 2,186 in 2003. Continued social and political stigmatization of IDU contributes to the risky behavior of sharing needles and injection equipment, increasing an IDU's risk for contracting HIV.

IDU are at risk for HIV infection when they share needles or syringes, a spoon or a cooker, glass of water or other fluid, and cotton or other absorbent material. These items are collectively known in street terminology as "works." In addition this includes the sharing of needles for tattooing, body piercing, or for the injection of steroids, vitamins and/or hormones. It is important to note that the sexual partners and unborn children of injection drug user's are also at increased risk for HIV infection.

Injection drug users cannot be identified by where they live or how much they earn. IDU may be any race, gender, age, ethnicity or sexual orientation, and may have other unique needs. The behavioral characteristics of IDU who are at risk of HIV infection, re-infection or transmission follow.

BEHAVIORAL CHARACTERISTICS: IDU

Certain behaviors may increase the level of risk for this population, including the following, which are <u>not</u> listed in order of priority:

- Using or abusing prescription drugs, alcohol and other chemicals
- Engaging in unprotected sex
- Exchanging unprotected sex for money, goods, drugs and/or survival needs
- Injecting vitamins and/or steroids or hormones
- Engaging in unlicensed body piercing or tattooing

FACTORS THAT MAY AFFECT THE ADOPTION AND MAINTENANCE OF HIV RISK REDUCTION BEHAVIOR: IDU

- Drug priorities ~ physiological and psychological power of drugs and drug use
- Peer pressure
- Self-efficacy and self esteem issues
- Lack of resources (including non-judgmental pharmacies, needle exchanges, healthcare, safer shooting techniques, mentors, treatment)
- Fear of being exposed as an injection drug user while accessing services

CRITICAL NEEDS: IDU

Based on review of needs assessment data and member expertise, the following is a list of critical needs that exist for this population. These needs are directly related to the factors that affect risk mentioned above and may be useful in designing interventions. They are <u>not</u> listed in order of priority.

- Increase motivation, intention and commitment to reduce high risk behaviors in a variety of situations and circumstances.
- Increase norms de-stigmatizing drug use.
- Increase use of risk reduction practices.
- Increase awareness of peer pressure and social norms that impact HIV transmission.
- Increase community norms and peer support of behaviors that reduce the risk of HIV transmission.
- Increase communication, problem solving and decision making skills that reduce HIV transmission.
- Increase knowledge of HIV status through low barrier, non-judgmental outreach CTR.
- Increase knowledge of HIV prevention and transmission including how to clean works, obtain sterile needles and syringes, use condoms and practice safer sex.
- Increase knowledge of HIV and hepatitis C related services, resources and support.
- Include STD and hepatitis messages during outreach to this population.
- Refer IDU for hepatitis C testing.
- Refer IDU for hepatitis A/B vaccine.

CRITICAL SYSTEM NEEDS: IDU

In addition to the specific needs listed above for IDU, there are broad systems needs that are the responsibility of different programs and agencies within the State that are important for this population. The CPG feels that is critical that these needs be met in order for HIV prevention to occur. The CPG encourages collaboration and cooperation between agencies, funders and providers to ensure that these needs are addressed. The following system needs were identified by the CPG for IDU and are not listed in order of priority.

- Increase access to clean needles through increasing the number and accessibility of needle exchanges, and assuring easy access to new needles through pharmacy sales.
- Increase access to treatment and health care.
- Develop advocacy related to access issues.
- Integrate sexual transmission risk with needle sharing risk.
- Develop consistent messages on how effective bleaching is for HIV and hepatitis C prevention.
- Increase access to counseling to treat unresolved psychiatric issues (mental illness, trauma, etc.) that results in self-medication.
- Increase access to substance abuse and mental health services particularly services that can accommodate women and single parents and are available to people who do not have private insurance or Medicaid.
- Advocate for structural changes that would decrease discrimination, stigmatization and punitive legal measures.
- Coordinate appropriate referrals to housing, healthcare, drug treatment, childcare, food, clothing, mental health care, domestic violence, etc.

ADDITIONAL RESOURCES: IDU

Center for AIDS Prevention Studies at the University of California San Francisco, "Fact Sheet 51E: What are injection drug users (IDU) HIV prevention needs?" available on the web at: http://www.caps.ucsf.edu/capsweb/

Center for AIDS Prevention Studies at the University of California San Francisco, "Fact Sheet 5ER: Does Needle Exchange Work?" available on the web at: http://www.caps.ucsf.edu/capsweb/

Academy for Educational Development (2000). *A comprehensive approach: Preventing blood-borne infections among injection drug users.* CDC, Georgia. Available on the Internet along with other related material at http://www.cdc.gov/hiv/projects/idu-ta.

PRIORITY 4: Heterosexual Females who have Unsafe Sex (HET)

BEHAVIORAL POPULATION DESCRIPTION: HET

As a priority population in this Plan*,* Heterosexuals who have Unsafe Sex refers to females who engage in unsafe behaviors that could place them at high risk for HIV infection from their opposite sex partner because that partner is HIV+, an injection drug user or is a male who also has sex with other males. See the behavioral descriptors below for more details.

Overall heterosexual females are at greater risk for contracting HIV than are their heterosexual male counterparts. Within this population, HIV is much more readily transmitted from male to female than from female to male (Padian, Shiboski, Glass, and Vittinghoff, 1997). Most HIV infection results from HIV+ male partners, who having contracted HIV through injection drug use or sex with other males, transmit the infection to their female partners (Campbell, 1995). Therefore, pertinent information related to this population may be found in the Population Descriptions for "Males who have Unsafe Sex with Males (MSM)" and "Injection Drug Users who Share Needles or Injection Equipment (IDU)."

At highest risk are heterosexual women who are unknowingly partnered with someone who is HIV+, IDU or MSM. In order to reach these women the CPG believes that outreach should target women who are:

- Incarcerated or in pre-release centers
- Living in shelters (battered women, youth and homeless shelters)
- In substance abuse treatment (including Methadone treatment) facilities
- Currently diagnosed with gonorrhea or syphilis

REFERENCES

Padian, N., Shiboski, S., Glass, S., Vittinghoff, E. (1997). Heterosexual transmission of Human Immunodeficiency Virus (HIV) in northern California: Results from a ten-year study. *American Journal of Epidemiology,* 146(4): 350-356.

Campbell, C. (1995). Male gender roles and sexuality: Implications for women's AIDS risk and prevention. *Social Science Medicine,* 41(2): 197-210.

BEHAVIORAL CHARACTERISTICS: HET

Certain behaviors may increase the level of risk for this population, including the following, which are <u>not</u> listed in order of priority:

- HIV+ individuals who have unprotected sex with their partner(s)
- Females who have unprotected sex with needle sharers

- Females who have unprotected sex with Gay, bisexual and non-Gay identified males who have sex with males
- Females who trade unprotected sex for money, goods, drugs and/or survival needs
- Females who have unprotected sex with multiple sex partners
- Females who use/abuse alcohol and/or other non-injection drugs especially cocaine and methamphetamines and also engage in unprotected sex

FACTORS AFFECTING THE ADOPTION AND MAINTENANCE OF HIV RISK REDUCTION BEHAVIOR: HET

- Lack of awareness of personal risk including not being aware of partner's risk, or being in denial of partner's risk.
- Fear related to testing due to stigma and confidentiality; need for anonymity and for testing locations other that their usual healthcare provider.
- Inability to negotiate safer behaviors with partner (including gender and power imbalances, issues of self esteem, etc.).

CRITICAL NEEDS: HET

Based on review of needs assessment data and member expertise, the following is a list of critical needs that exist for this population. These needs are directly related to the factors that affect risk mentioned above and may be useful in designing interventions. They are <u>not</u> listed in order of priority.

- Increase awareness of risk and perceived susceptibility and vulnerability.
- Increase knowledge of status through low barrier, targeted outreach CTR.
- Increase self-esteem and confidence that one can use risk reduction behaviors under a variety of situations and circumstances.
- Increase communication, problem solving and decision making skills that reduce HIV transmission including negotiation skills, and skills related to power imbalances that lead to empowerment and assertiveness.
- Include STD and hepatitis messages during outreach to this population.
- Provide risk assessment and referrals for hepatitis C testing as appropriate.
- Provide risk assessment and referrals for hepatitis A/B vaccine as appropriate.

CRITICAL SYSTEM NEEDS: HET

In addition to the specific needs listed above for HET, there are broad systems needs that are the responsibility of different programs and agencies within the State that are important for this population. The CPG feels that is critical that these needs be met in order for HIV prevention to occur. The CPG encourages collaboration and cooperation between agencies, funders and providers to ensure that these needs are addressed. The following system needs were identified by the CPG for HET and are not listed in order of priority.

- Increase access to substance abuse and mental health services particularly services that can accommodate women and single parents and are available to people who do not have private insurance or Medicaid.
- Advocate for structural/environmental changes to decrease stigmatization.

ADDITIONAL RESOURCES: HET

Center for AIDS Prevention Studies at the University of California San Francisco, "Fact Sheet 4ER: What are women's HIV prevention needs?" available on the web at: http://www.caps.ucsf.edu/capsweb/

Center for AIDS Prevention Studies at the University of California San Francisco, "Fact Sheet 45ER: What are young women's HIV prevention needs?" available on the web at: http://www.caps.ucsf.edu/capsweb/

Recommendations Regarding Critical Systems Needs

In addition to the system needs mentioned above that are specific to each particular target population, there are broad system needs that effect all populations and fall under the responsibility of various programs and agencies within the State. The CPG feels these systemic needs have to be addressed in order to assure HIV prevention and quality service provision. The CPG encourages collaboration and cooperation between agencies, funders and providers to ensure that these needs are addressed.

- To maximize shrinking budgets available for HIV prevention efforts, the CPG considers it imperative to leverage existing resources and service delivery through greater coordination at federal, state and local levels. To facilitate this at the state and local level, the CPG strongly recommends establishment of a cross-disciplinary work group from state government agencies, to include Department of Education (DOE), Department of Labor (DOL), Department of Corrections (DOC), Behavioral and Developmental Services (BDS), Office of Substance Abuse (OSA), and the Department of Human Services (DHS) which includes the Bureau of Medical Services (BMS), Bureau of Elder and Adult Services (BEAS), and the Bureau of Health (BOH).
- The establishment of this workgroup should be coordinated by the Bureau of Health.

This workgroup is charged with addressing the following priority system needs that cut across all populations at high risk for HIV:

- Ready access to affordable health care services including Mental Health and Substance Abuse Treatment.
- Integration of HIV/STD/hepatitis risk assessment and prevention counseling into routine healthcare services, including social services and substance abuse and mental health.
- Development of programs to educate Maine citizens of the risks of HIV/STD/hepatitis in Maine.

STRATEGIES TO MEET SYSTEMS NEEDS

- Advocate use of the *CPG Comprehensive HIV Prevention Plan* by all State agencies and their contracted providers.

- Review needle exchange legislation and recommend elimination of limits on the number of syringes that can be exchanged.
- Advocate for methadone clinic expansion and buprenorphine availability including within the correctional system (both jails and prisons).
- Develop protocols and methods to require that substance abuse and mental health providers include HIV/STD/hepatitis risk reduction assessment and prevention into their services.
- Develop a comprehensive resource list of HIV/STD/hepatitis services.
- Identify human resources that can advise on special issues for racial and ethnic minorities, and immigrant and refugee populations.
- Develop better training for professionals in the healthcare professions relative to HIV/STD and hepatitis.

Chapter 5
INTERVENTIONS: SAFE IN MAINE

This Chapter provides an overview of the Serostatus Approach to Fighting the HIV/AIDS Epidemic (SAFE) model which the CPG has recommended as the basis for prevention planning throughout the State. It also includes a chart that reviews the different intervention types as categorized by the CDC and used by the Maine Bureau of Health. The last section of this Chapter lists interventions recommended by the CPG for use in implementing SAFE in Maine.

AN OVERVIEW OF THE SAFE MODEL

As was mentioned in Chapter 3, the CPG has adopted the SAFE model which requires activities be focused on recruiting people at high risk for HIV infection into Counseling, Testing and Referral services (CTR), and then addressing the prevention needs of people who test HIV+ or who are very high-risk negative. It is aimed at those who are HIV-infected, including those not aware of their status, as well as those who have been tested and found to be uninfected but are at continued very high behavioral risk. Providers should incorporate the SAFE model into their prevention programs in order to identify activities that would effectively recruit members of the targeted behavioral populations into CTR and risk assessment services. CPG recommendations of venues for recruitment and outreach CTR can be found on pages 44-45.

- In this Plan the term "**high risk**" refers to persons of unknown or negative serostatus engaging in behaviors that put them at risk for HIV or other STD's with people who are HIV+, or in settings where there is a high prevalence of HIV.
- "**Very high risk**" refers to someone who, within the past 6 months:
  - has had unprotected sex with a person who is living with HIV
  - has had unprotected sex in exchange for money or drugs
  - has had multiple (greater than 5) or anonymous unprotected sex or needle-sharing partners
  - has been diagnosed with a sexually transmitted disease.

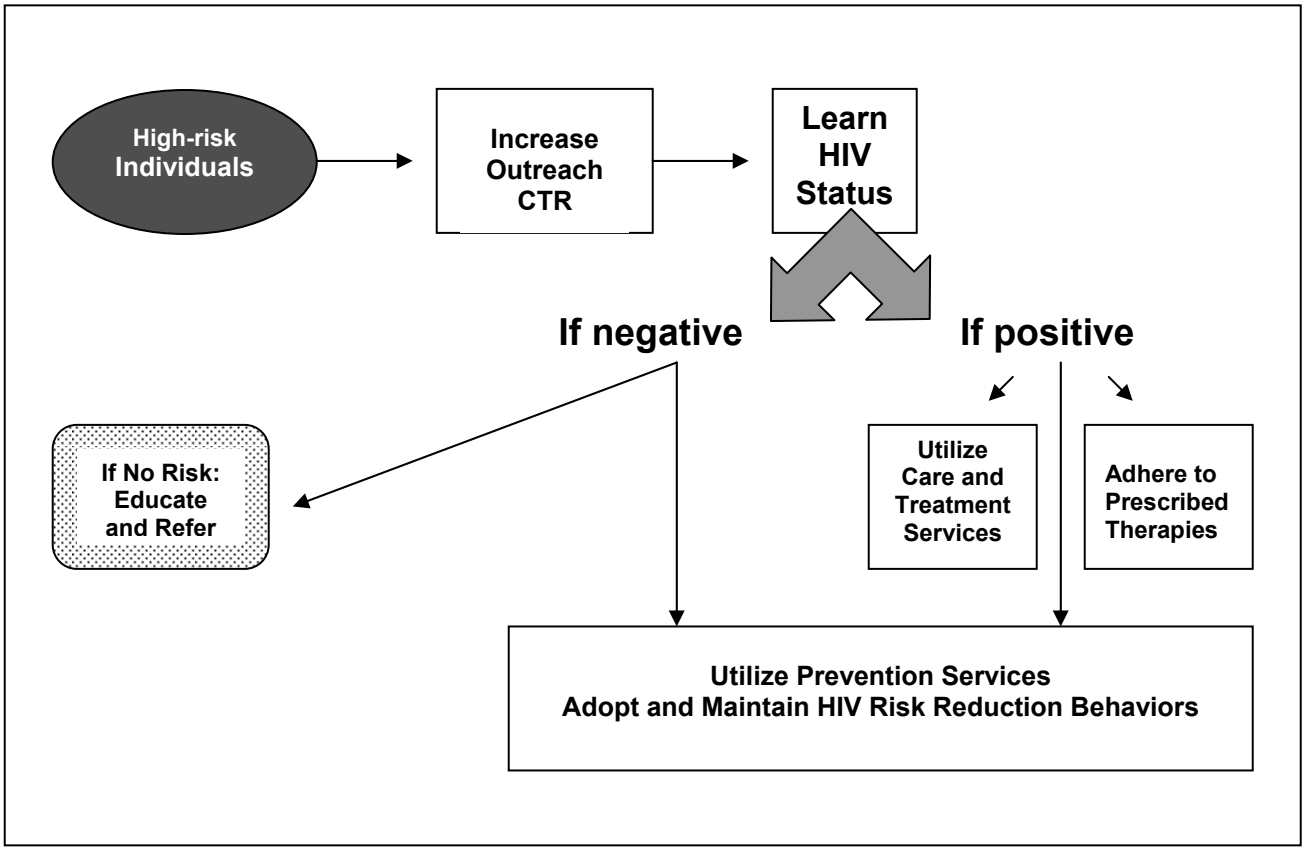
The following information provides an overview of SAFE*. All prevention services should be based on this model with a focus on outreach CTR to populations at high risk of infection. This results in a two tiered system of activities/interventions:

1. Interventions to recruit people at high risk to test and learn their serostatus
2. Follow-up HIV prevention interventions for people who test positive or who test negative but are at very high risk of becoming infected.

The 5 steps of the SAFE model* are as follows:

1. Increase the number of HIV-infected persons who know their serostatus ~ encourage testing by those at risk
2. Increase the use of health care and prevention services by HIV+ persons
3. Increase the number of HIV+ persons receiving high-quality care and treatment
4. Increase adherence to antiretroviral therapies
5. Increase the adoption and maintenance of HIV risk reduction behaviors by people who are HIV-infected or at high risk.

The blueprint for a serostatus approach to fighting the HIV/AIDS epidemic:



Examples of How to Implement Serostatus-Specific HIV Prevention Interventions*

Population	HIV Prevention Interventions
Unaware of serostatus; behavioral risk of infection	Provide current, essential HIV-related information Encourage voluntary HIV counseling and testing among those at increased risk including anonymous testing Reduce stigma of HIV disease and services
Recently tested HIV negative; no apparent behavioral risk of infection	Educate to provide HIV prevention messages to family, friends, partners
Recently tested HIV negative; behavioral risk of infection	Offer intensive individual or small-group counseling Develop community-level interventions Establish linkages to STD, substance abuse, mental health, hepatitis, and social services as needed Provide prevention case management for those at highest risk Develop structural interventions (e.g., sterile syringe access)
Tested HIV positive	Provide intensive prevention services Offer partner counseling and referral services Establish linkages to STD, substance abuse, mental health, hepatitis, and social services as needed Provide prevention case management Develop structural interventions (e.g., decrease discrimination)

***** The information on SAFE was adapted from the following source:
Janssen, Robert S. et al. (2001). The serostatus approach to fighting the HIV epidemic: Prevention strategies for infected individuals. *American Journal of Public Health* 91(7): 1019-1024.

INTERVENTION TYPES

The following chart provides a general overview of different types of interventions as categorized by the CDC and used by the Maine Bureau of Health. This listing can be helpful in understanding the interventions recommended for targeted recruitment, as well as those recommended for people who are HIV+ and for people who are very high risk HIV negative.

This chart suggests which intervention type would be appropriate to use to address the critical needs of the priority populations. See Chapter 4 for information regarding the critical needs of each of these populations. See the last section of this Chapter for the actual recommendations regarding CTR and HIV prevention interventions.

Intervention Type	***Description***	
Individual Level (ILI)	Health education and/or risk reduction counseling provided to one person at a time. ILI's assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior and include skills building activities. These interventions also help clients make plans to obtain services in clinics and community settings in support of behaviors and practices that prevent the transmission of HIV.	
	Examples/Method	**Recommended/Effective in addressing**
	Single Session	HIV knowledge, information, referrals, skills
	Multi Session	Attitudes, skills and behaviors
	Peer-Led	Recommended for all interventions targeting youth, females and people of color. Can be single- or multi-session

Group Level (GLI)	Health education and/or risk reduction counseling with a skills building component provided to more than one person at a time. Provide education and support in group settings to promote and reinforce safer behaviors and to provide interpersonal skills training in negotiating and sustaining appropriate behavior change to persons at increased risk or already infected.	
	Examples/Method	**Recommended/Effective in addressing**
	Single Session	HIV knowledge, information, referrals, skills
	Multi Session	Attitudes, skills and behaviors
	Peer-Led	Recommended for all interventions targeting youth, females and people of color. Can be single- or multi-session

Community Level (CLI)	Health education and/or risk reduction services directed at changing community norms, rather than those of the individual or a group, to increase community support of the behaviors known to reduce the risk of HIV transmission. The primary goals of these interventions are to improve health status, to promote healthy behaviors, and to change factors that affect the health of community residents. They are designed to promote community support of prevention efforts by working with the social norms or shared beliefs and values held by members of the community. Community may be defined in terms of a prioritized population or a geographic area as a way to capture the social networks that may be located within those boundaries.	
	Examples/Method	**Recommended/Effective in addressing**
	Community Building Events	Community norms, populations with strong identifications, isolated populations, addressing issues in a culturally competent way
	Social Marketing	See above
	Structural/Systems Interventions	See above
	Town Meetings	See above

Outreach (OR)	Interventions are defined by the location of activity and by the content of services provided. They reach persons at high risk, individually, or in groups, on the street or in community settings. The fundamental principle of outreach activities is that the outreach worker establishes face-to-face contact with the client in his or her environment to provide HIV risk reduction information, safer sex/harm reduction products, and referrals. It may be a recruitment strategy. The outreach intervention may happen distinctly or in conjunction with other interventions.	
	Examples/Method	**Recommended/Effective in addressing**
	Peer Education	HIV knowledge, information, referrals, safer sex/harm reduction products, recruitment into other interventions, reaching high risk individuals
	"Street Outreach"	See above
	Needle Exchange	See above
	Popular Opinion Leaders	See above

Counseling, Testing and Referral (CTR)	An Individual Level Intervention. Component of an effective HIV prevention intervention activity by which a person may learn their HIV sero-status. CTR services are offered free of coercion. Individuals have the opportunity to accept or refuse HIV testing. Can increase knowledge about HIV transmission/acquisition, knowledge of status, and change attitudes related to risk and testing.	
	Examples/Method	**Recommended/Effective in addressing**
	Anonymous	Low barrier service. High risk clients. Can be done in an outreach setting
	Confidential	Can be done in outreach setting
	Oral	Can be done in outreach setting
	Rapid Test	Can be done in outreach setting
	Serum	Clinic setting

Partner Counseling and Referral Services (PCRS)	A voluntary and confidential prevention activity conducted by trained individuals that provides services to a source patient and their sex and/or needle-sharing partners so they can reduce their risk for infection or, if already infected, may prevent transmission to others. PCRS also works to help partners gain earlier access to individual counseling, HIV testing, medical evaluation, and other prevention and support services.	
		Recommended/Effective in addressing
		Continuation of CTR, reducing risk of partners, early entry into testing, treatment and services

Prevention Case Management (PCM)	Provides client-centered, intensive, on-going, individualized prevention counseling, support, education and service referral. The goal is to promote the adoption and maintenance of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs. It is intended for persons having difficulty initiating or sustaining behaviors that reduce or prevent HIV acquisition, transmission, or re-infection.	
		Recommended/Effective in addressing At risk HIV + individuals, individuals at high risk for HIV with multiple, complex problems and risk-reduction needs.

Health Communication/ Public Information (HC/PI)	Information delivered as planned prevention messages to support risk-reduction, increase awareness, build support for safer behavior. HC/PI does not include group level interventions that include a skill component. Can be used for recruitment.	
	Examples/Methods	**Recommended/Effective in addressing**
	Hot line	Basic HIV information and information on services and support. Delivering targeted information to specific populations.
	Presentations/lectures	"One shot" education intervention delivering targeted information to specific populations in group settings such as jails or substance abuse treatment facilities.
	Electronic & Print Media	Media campaigns delivering targeted information to specific populations.
	Clearinghouse/Internet based	Basic prevention messages and referral information delivered to MSM on line.

RECOMMENDATIONS FOR CTR, VENUES AND HIV PREVENTION INTERVENTIONS

The following Tables list the recommended activities and interventions that should be used when working with the high risk* prioritized populations in this Plan. See Chapters 3 and 4 for details on these populations and their prevention priorities. Table I lists recommended activities to recruit people into Counseling, Testing and Referral Services (CTR), Table II lists recommended interventions for people who are HIV+, and the Table III lists recommended interventions for people who test negative but are at very high-risk*. The activities and interventions listed in these tables are not in priority order.

The CPG recommendations for interventions listed in these Tables include CDC evaluated interventions as well as other general intervention types (see the previous Chart). The CDC evaluated interventions are listed in **bold** type in Table I. It is important that when program planners modify these CDC interventions, that the modification is culturally competent, suits the specific needs of the populations being served, and maintains the core elements of the original intervention. According to the CDC, core elements are those components that are critical features of an intervention's intent and design and are considered to be responsible for its effectiveness. They are essential to the implementation of the program and cannot be ignored, added to, or changed.

- Further information about these CDC evaluated interventions and their core elements is available on the Disseminating Effective Behavioral Interventions (DEBI) project website at http://www.effectiveinterventions.org, and the Replicating Effective Programs (REP) project website at http://www.cdc.gov/hiv/projects/rep/ .

- When choosing one of the CDC interventions listed in Table I, the core elements (as listed on the DEBI and REP websites) must be followed, however the interventions can be adapted (to a different population or venue) and tailored (changed to deliver a new message, or use a different timeframe, or be delivered in a different manner) than was originally described.

In addition, the CPG continues to recommend that all HIV prevention providers use the information in contained in Chapter 6 regarding criteria for effective interventions and programs, and use behavioral/social science theory in their HIV prevention planning.

*As mentioned previously, the term "**high risk**" refers to persons of unknown serostatus engaging in behaviors that put them at risk for HIV or other STD's with people who are HIV+ or in settings where there is a high prevalence of HIV.
"**Very high risk**" refers to someone who, within the past 6 months:

- has had unprotected sex with a person who is living with HIV
- has had unprotected sex in exchange for money or drugs
- has had multiple (greater than 5), or anonymous unprotected sex or needle-sharing partners
- has been diagnosed with a sexually transmitted disease.

CTR RECOMMENTATIONS AND VENUES

COUNSELING, TESTING AND REFERRAL (CTR)

- The number one recommended intervention for all targeted behavioral populations is Counseling, Testing and Referral (CTR). The CPG makes the following recommendations for implementing CTR:

    - The primary method of CTR delivery should be field outreach.
    - CTR services must also be available on a regularly scheduled basis including some night or weekend hours and by appointment as needed.
    - CTR services for the prioritized populations should be available anonymous and free of charge.
    - All paid and volunteer staff conducting HIV prevention interventions are required to have Bureau of Health certification in CTR.
    - CTR services must be more aggressively promoted via marketing and media statewide.
    - Targeted outreach Group Level Interventions (GLI) and Individual Level Interventions (ILI) should be used as a strategy to get people to test.

VENUES

- In addition the CPG recommends the following venues for CTR and other outreach interventions. The venues are not listed in priority order.

Venues for Targeting MSM

- Websites such as manhunt.net, crusingforsex.com, and wardzero.com, etc.; Internet chat rooms such as aol.com, yahoo.com, and gay.com; and sex party hook ups using the Internet
- Adult bookstores and porn shops
- Bars
- Malls (Portland and Bangor)
- Ogunquit (summer)
- Mount Desert Island public sex environment (PSE)
- Bangor, Portland and Lewiston/Auburn public sex environments
- MSM community events such as Pride celebrations, retreats, etc.
- College LGBTI groups

Venues for Targeting IDU

- Drug treatment centers
- Second Offenders (DEEP) Programs for O.U.I.
- Coastal fishing venues
- Methadone Clinics
- Jails, prisons, and pre-release centers
- Homeless Shelters
- Soup Kitchens
- Group Homes/Halfway Houses
- Reservations
- Parks and rest areas
- Teen Centers
- Health Clinics
- Streets/areas known for sex work
- Mental Health Treatment & Counseling Centers
- Tattoo/Piercing Parlors
- Plasma Centers

Venues for Targeting HET Females

- Substance abuse facilities especially those targeting women
- Battered women's shelters
- Jails, prisons, pre-release centers
- Homeless shelters
- Youth shelters such as New Beginnings and Shaw House
- STD Clinics

INTERVENTION RECOMMENDATIONS

In keeping with the SAFE model, the activities and interventions listed in Table I below should result in Counseling, Testing and Referral (CTR) and risk assessment of individuals at high risk of HIV transmission/acquisition. **Bolded** items refer to CDC evaluated interventions which require the use of their core elements as described previously in this Chapter.

TABLE I

CPG Recommended Interventions & Activities to Encourage Testing for High-Risk Members of the Target Populations **(not listed in priority order)**
COUNSELING, TESTING AND REFERRAL (CTR) ~ primarily: • Targeted Outreach CTR (see recommended venues beginning on page 44)
COMMUNITY LEVEL INTERVENTIONS (CLI) as follows: • **Popular Opinion Leader** (adapted and tailored for implementation in Maine's Metropolitan Statistical Areas (MSA's) ~ Portland MSA, Lewiston MSA, and Bangor MSA) • **StreetSmart** (adapted and tailored for implementation in Maine's three MSA's) • **Mpowerment Project** (adapted and tailored for implementation in Maine's three MSA's) • **Popular Opinion Leader** (adapted and tailored for implementation in Maine's three MSA's) • Community wide events
HEALTH COMMUNICATION/PUBLIC INFORMATION including • Targeted, provocative, contemporary electronic and print media campaigns • Coordinated internet based interventions for MSM • Presentations/lectures delivering targeted information to specific populations in the community such as at jails and substance abuse treatment facilities (see recommended venues beginning on page 44)
INDIVIDUAL LEVEL INTERVENTIONS (ILI) including but not limited to: • **Project Respect** 2 session model
PARTNER COUNSELING, TESTING AND REFERRAL SERVICES (PCRS)
GROUP LEVEL INTERVENTIONS conducted both onsite and out in the community (see recommended venues on beginning on page 44)

CTR and risk assessment should lead to the following interventions in Table II (below) for people who tested HIV positive, or to the interventions in Table III (next page) for individuals who test HIV-negative but whose behaviors put them at very high risk.

TABLE II

CPG Recommended Interventions for People Who Test HIV Positive **(not listed in priority order)**
GROUP LEVEL INTERVENTIONS (GLI) Including social support groups which should be run by a trained facilitator (such as an LCSW or a trained peer) and not the case manager. They should be supportive in nature while working on the skills and obstacles mentioned under Critical Needs for People who are HIV+ in Chapter 4.
INDIVIDUAL LEVEL INTERVENTIONS (ILI) (Recommended for people who are newly diagnosed, and could include peer advocates/buddies)
PREVENTION CASE MANAGEMENT (PCM) (referral for people with multiple, complex issues and risk reduction needs that can't be served through GLI or ILI's)
HEALTH COMMUNICATION/PUBLIC INFORMATION (HC/PI) (Related to education about the disease and treatment options)
COMMUNITY LEVEL INTERVENTION (CLI) (Related to reducing stigma and encouraging disclosure as the norm)
PARTNER COUNSELING, TESTING AND REFERRAL SERVICES (PCRS)

TABLE III

CPG Recommended Interventions for People At <u>Very High-Risk</u> Who Test Negative **(not listed in priority order)**
INDIVIDUAL LEVEL INTERVENTION (ILI) • Single session ILI • Multi session ILI
GROUP LEVEL INTERVENTION (GLI) (Multi session including social support groups)
PREVENTION CASE MANAGEMENT (PCM) (Facilitated referrals for people at very high risk who have multiple, complex issues and risk reduction needs that can't be served through GLI or ILI's)
PARTNER COUNSELING, TESTING AND REFERRAL SERVICES (PCRS) (as appropriate)

Chapter 6

DESIGNING EFFECTIVE HIV PREVENTION PROGRAMS: Characteristics and Theory

This Chapter contains information about using behavioral and social science theory to develop interventions and prevention programs. The characteristics of effective interventions and programs are followed by an overview of behavioral and social science theories and their use in HIV prevention.

CHARACTERISTICS OF EFFECTIVE HIV PREVENTION INTERVENTIONS AND PROGRAMS

HIV prevention interventions for all populations must contain basic criteria. The Maine CPG, following the work of Jeffrey A. Kelley as well as other researchers, has accepted the following elements as being most important in making behavior change possible. Funding decisions should be based, at least in part, on these criteria. Interventions should reach a significant number of people from the priority population and prevent as many new infections as possible.

EFFECTIVE INTERVENTIONS:

- Clearly define the population at risk.
- Address a demonstrated need and are designed according to a needs assessment as well as the individual's level of motivation to change their behavior.
- Are based on behavioral and social science theory and research and may be adapted from effective interventions used elsewhere, if core elements of the original model are maintained.
- Are focused on reducing specific risk behaviors by providing (as needed):
    - Knowledge and understanding of the factors responsible for risk and the behavioral changes needed to reduce/avoid risk of HIV infection. Myths and misconceptions about HIV/AIDS are corrected.
    - Counseling, Testing and Referral (CTR) services.
    - Opportunities to practice relevant skills including condom and lubrication use, safer sex practices, assertiveness skills, negotiation and communication skills, and self-management skills to reduce risk vulnerability.
    - Assistance in accurately appraising one's personal level of risk (threat personalization).
    - Assistance in the development of self-efficacy (belief that one can effectively make behavioral changes and that change will reduce ones risk).
    - Assistance in planning and strategizing ways to avoid and cope with high-risk situations and/or lapses.

- Address barriers by:
    - Being delivered at a location that is accessible and acceptable to the target population and at a time that is convenient to the population and most likely to reach the greatest number of people who are at risk.
    - Providing stipends, travel expenses, childcare or other incentives if needed.
    - Providing accommodations for people with disabilities.
- Are measurable with clearly defined goals and objectives.
- Are client centered, tailored to client's relationship/risk circumstance and focus on client empowerment, not manipulation.
- Are culturally appropriate and actively involve members of the target population in the planning, implementation and evaluation of the intervention. Messages are linguistically appropriate and tailored to the specific gender, sexual orientation and identity, race, ethnicity, culture, age, socioeconomic status, and educational level of the target population.
- Are cost effective and not duplicated.
- Allow for sufficient time and intensity of the intervention to achieve and maintain behavior change.
- May address community wide norms, attitudes, beliefs and values providing consistent messages and reinforcement for behavior change.
- May promote the development of support networks, community building and necessary referrals to sustain behavior change over time.

SUCCESSFUL HIV PREVENTION PROGRAMS:

- Integrate with the larger HIV prevention and human service delivery system providing a holistic continuum of health care. They are comprehensive and collaborate with other service organizations and agencies, providing appropriate referrals to community based programs. Particular attention should be given to:
    - Linkages between primary and secondary prevention
    - Issues of alcohol and other drug use and abuse
    - Hepatitis-related services
    - Physical, sexual, emotional abuse whether past, present or potential
    - Other sexually transmitted disease testing and treatment
    - Family Planning
    - HIV Counseling, Testing and Partner Notification components of HIV prevention (PCRS)
    - Risk-reduction or relapse prevention counseling
    - Other health services including mental health and other social services, tuberculosis testing, etc.
    - Other basic needs including housing, food, etc.

- Provide supervision on a regular basis.
- Develop a Code of Ethics addressing non-discrimination, competence, integrity, relationships with clients, and confidentiality.
- Incorporate quality assurance measures and develop protocols for interventions that include the safety of staff, volunteers and clients.
- Implement a procedure that allows client feedback regarding the services they receive and a procedure to address complaints.
- Use ongoing program evaluation to modify interventions to better meet the needs of the target population.
- Provide consistent prevention messages about risk factors and risk reduction in all related programming.
- Have adequate funding, staff and agency buy-in for the program.
- Provide ongoing development and training of staff and volunteers in core elements of the interventions and other related/relevant topics including cultural sensitivity and professional ethics.

USING BEHAVIORAL AND SOCIAL SCIENCE THEORIES IN HIV PREVENTION

Before choosing interventions, it is crucial to understand which interventions are the most effective and why. Behavioral Science, the study of human behavior, seeks to explain how behavior is influenced and modified. It examines what people do, who they do it with, how they change their behavior over time, and the factors that can influence them to make different choices. This can provide important information about why some HIV prevention methods are more effective than others in changing or reducing behaviors that put people at risk for HIV infection.

A behavioral intervention is based on behavioral science theory and practical experience with the aim of changing the HIV risk behavior(s) of an individual, group, or community. Evaluations of HIV prevention interventions demonstrate that those based on sound theoretical models are the most effective at encouraging behavior change (Fisher and Fisher, 1992; Holtgrave et al., 1995; Valdiserri, 1992). A theory-based plan is implemented and then evaluated and the results are used to decide whether the intervention worked, needs modification, or another approach should be tried. Multiple interventions or approaches to reach the target population form the basis of an HIV prevention program. In this way the multiple needs of the population are addressed. In designing interventions, it is important to make use of interactive as well as didactic techniques, and verbal as well as written and visual methods of presentation. Members of the prioritized populations should be involved in all phases of planning, implementation and evaluation.

A number of formal theories have proven useful in HIV prevention intervention design and are summarized in the literature. Formal behavioral theories are developed to explain certain behaviors, are tested scientifically, and can be applied to a variety of people or situations. These theories can help service providers understand the various components of behavior and the steps that commonly lead to behavior change. Also, behavior theory can be used to understand the complexities of the behaviors that providers target in their prevention programs. These benefits can facilitate determining the design and goals of any intervention. Thus, using theories can help improve the overall quality of interventions and conserve limited resources.

While useful, behavior theory is not the only determinant of a successful HIV intervention program. Rather, behavior theory best enhances HIV program planning when it is a component of a process that involves 1) assessing the risk behaviors and cofactors of the target population, 2) considering the strengths and weaknesses of potential HIV interventions and choosing those that best address the needs of the target population, and 3) working from an awareness of the organizational, community and cultural context in which HIV occurs (McLeroy et al., 1993). Modification of theories and combining various theories to meet the needs of particular issues or populations is recommended.

OVERVIEW OF BEHAVIORAL SCIENCE THEORIES AND THEIR APPLICATION TO HIV PREVENTION

Theory is one of many tools that can have an important influence on HIV prevention programs. Eleven of the most widely known general theories are presented below. Many of the theories have common or related elements. These theories are not mutually exclusive, nor are they HIV specific, but they can work together to develop interventions and guide effective programs. When designing HIV prevention interventions, more in-depth research into these theories is recommended.

Health Belief Model (Janz, Becker)

Overview and Application to HIV Prevention

The key component for this theory is the belief that the benefits of performing a behavior(s) outweigh the consequences of not performing it. The Health Belief Model is based on the premise that health related behaviors depend on four key beliefs, all of which have to be present in order for a new behavior to be adopted.

- **Perceived Risk**: people are motivated for behavior change when they believe they are personally vulnerable to the disease.
- **Perceived Severity:** people must believe that the disease or condition poses an actual threat to their personal health and well-being.
- **Perceived Benefits/Effectiveness:** people must believe that there is something that can be done to prevent the disease.
- People must believe that perceived **barriers** to change **can be overcome** and that the benefit outweighs the effort.

Additionally, the model suggests that a specific stimulus or "**cue to action**" is often required to trigger the behavior change process (Petrosa and Jackson, 1991). This "cue to action" can be positive or negative and can include personal and social influences such as media messages or witnessing the illness of a close friend or family member.

Usefulness in HIV Prevention

- Service providers can separately target the beliefs necessary for behavior change and the barriers to prevention.
- It can be used to design interventions to change behavior regardless of the target population's demographic characteristics so long as the intervention components are culturally appropriate (Abraham and Sheeran, 1994).

Considerations

- It relies heavily on the presence of cues to action in people's environments, which requires extensive and diverse interventions for targeted communities.
- It has limited effectiveness in changing habitual behavior or addictions.

Program Application
A program using the Health Belief Model might design a needs assessment to include questions such as:

- Does the person see him/herself at risk for that condition?
- Does s/he believe that adopting risk reduction behaviors will decrease their risk?
- What are the barriers to adopting the new behavior?
- Does one's social network encourage or discourage adoption of the new behavior?
- What types of media does the target group most frequently use?

Additional Information:
The following sources may be useful in learning more about the Health Belief Model.

Becker, M.N. (1988). AIDS and Behavior Change. *Public Health Review*, 16, 1-11.

Janz, N.D. and Becker, M.H. (1984). The health belief model: A decade later. *Health Education Quarterly,* 11, 1-47.

Kirscht, J.P. and Joseph, J.G. (1989). The health belief model: Some implications for behavior change with reference to homosexual males. In Mays, V.M., Albee, G.W., and Schneider, S.F. (Eds.), *Primary* p*revention of AIDS*: *Psychological approaches*. Newbury Park CA: Sage Publications.

Rosenstock, I.M., Strecher, V.J., Becker, M.H. (1994). The health belief model and HIV risk behavior change. In DiClemente, R.J. (Ed.), *Preventing AIDS: Theories and methods of behavioral interventions*. New York, NY: Plenum Press.

Theory of Reasoned Action (Ajzen & Fishbein)

Overview and Application to HIV Prevention
Theory of Reasoned Action focuses on how beliefs and perceptions of threat to self lead to intentions to change risky behavior. In order for behavior change to occur, one must have an intention to change. A persons attitudes and beliefs toward the behavior as well as the perception of what significant others think, influence their intentions toward changing their behavior. The theory emphasizes the importance of attitudes and intentions as a prerequisite to behavior change.

- Risk reduction behavior begins with a person's **attitude** that the behavior will lead to positive outcomes.
- This attitude leads to the **intent to perform** a specific behavior.
- The strength of a person's **intention** to undertake the behavior change **depends on** the influence of his or her immediate **social environment** and general **social norms ~ Social Influence**.

The Theory of Planned Behavior was added to this theory to include "…perceived behavioral control." Perceived Behavioral control is determined by two factors:

- Control Beliefs
- Perceived Power

(Kelli McCormack Brown – http://hsc.usf.edu/~kmbrown/TRA_TPB.htm)

Usefulness in HIV Prevention

- A strength of this theory is that it incorporates the social aspects of human behavior.
- The focus on attitudes and subjective norms suggests an HIV intervention on the community level to influence the perceptions of target groups.

Considerations

- The focus on attitudes and intentions, while predictive of some behaviors, neglects issues of relapse and behavior maintenance.
- Larger social and environmental issues are not highlighted as influences on norms and behaviors.

Program Application

A program using the Theory of Reasoned Action might conduct a needs assessment to determine:

- Client's attitudes about adoption of risk-reduction behaviors.
- If clients express an intention to change any risk-related behaviors.
- Client's perception about the attitudes and behaviors of their peers.

Additional Information:

The following sources may be useful in learning more about the Theory of Reasoned Action.

Ajzen, I. and Fishbone, M. (1980). *Understanding attitudes and predicting social behavior.* Englewood Cliffs NJ: Prentice-Hall.

Fishbein, M. and Ajzen, I. (1975). *Belief, attitude, intention and behavior: An introduction to theory and* research. Boston MA: Addison-Wesley.

Fishbein, M., Middlestadt, S. E. (1989). Using the theory of reasoned action as a framework for understanding and changing AIDS-related behaviors. In Mays, V.M., Albee, G.W., and Schneider, S.F., (Eds.), *Primary prevention of AIDS: Psychological approaches.* Newbury Park CA: Sage Publications.

Cognitive-Social Learning Theory (Bandura)

Overview and Application to HIV Prevention

Cognitive-Social Learning Theory is based on the premise that behaviors are learned

through direct experience or by modeling the behavior of others through observation. It emphasizes the interaction between behavior, social, and physical factors, and maintains that a change in anyone of these factors influences the others. New behaviors often require the **acquisition of new skills**. The chance of a behavior(s) being repeated is based on the person's assessment of the benefits/costs. Key aspects of the theory include:

- **Information provision** is a first step in behavior change. Individuals are not even considering a change if they have no information about the risk and how it could affect them ~ **Knowledge**.
- **Outcome expectancies** are the extent to which a person values the expected outcome of a specific behavior ~ the expected positive or negative consequences of a behavior. Seeing the rewards (or costs) of a behavior for someone else is one way to develop these expectations.
- **Self-efficacy** is the belief that one is capable of performing a particular behavior and is confident in one's ability, even if it involves challenge. Self-efficacy can be developed by observation of others or by direct practice and experience.
- **Social competency/support** is the extent to which an individual can express and negotiate their needs with others and gets support from others ~ **Social Influence**.

Usefulness in HIV Prevention

- The importance of **self-efficacy** is a particular contribution of Social Learning Theory.
- Perceived self-efficacy to negotiate condom use with partners has proved a strong predictor of sexual behavior change among gay men (Emmons et al., 1986; McKusick et al., 1990), adolescents (Hingson et al., 1990), and college students (Basen- Engquist, 1994).
- Useful for identifying psychological and environmental factors that may affect behavior change.

Considerations

- The theory is focused on the individual rather than changing group or community norms, which limits the extent to which broad-ranging changes in the HIV epidemic can occur.
- Known risk factors for HIV infection such as the bio-psycho-social components of addictive behaviors and other profound psychological issues are not easily addressed by this theory.

Program Application

A program using Social Cognitive Theory might assess:

- How much experience people have in talking to their partners about condom use.
- What types of situations present the greatest barriers to practicing risk-reduction behaviors?
- Whether people think that adopting risk-reduction behaviors would produce positive or negative consequences.

Additional Information:
The following sources may be useful in learning more about the Social Learning / Cognitive Theory.

Bandura, A. (1977). *Social Learning Theory.* Engelwood Cliffs: Prentice-Hall.

Bandura, A. (1977). *Social foundations of thought and action: A social-cognitive theory.* Englewood Cliffs: Prentice-Hall.

Bandura, A. (1989). Perceived self-efficacy in the exercise of control over AIDS infection. In Mays, V.M., Albee, G.W., and Schneider, S.F. (Eds.), *Primary prevention of AIDS: Psychological approaches.* Newbury Park CA: Sage Publications.

Bandura, A. (1991). A social cognitive approach to the exercise of control over AIDS infection. In DiClemente, R. (Ed.), *Adolescents and AIDS: A generation in jeopardy.* Newbury Park CA: Sage Publications.

Bandura A. (1994) Social cognitive theory and exercise of control over HIV infection. In DiClemente, R.J. (Ed.), *Preventing AIDS: Theories and methods of behavioral interventions.* New York, NY: Plenum Press.

Transtheoretical (Stages of Change) Model (Prochaska, DiClemente & Norcross)

Overview and Application to HIV Prevention
The premise of the Stages of Behavior Change Model is that behavior change takes place in a series of stages, and each stage depends on having passed through the previous one. A stage can last an indeterminate amount of time. People do not necessarily pass through stages sequentially and may repeat stages. Relapse is viewed as a normal process in a persons attempt to change behaviors. The five stages are:

- **Pre-contemplation** – Before a person is aware of the negative effects of a particular behavior, there is no intention to change. They may be unaware of their risk, or believe that their behaviors do not expose them to risk. They see no need to change. This stage is related to knowledge, attitudes and beliefs.
- **Contemplation** – A person has become aware of the hazards of the behavior, but is not yet certain about whether the necessary change is worth the effort. They are ambivalent about the benefits of making the change versus what they risk by trying to make the change. This stage is related to attitudes and beliefs, self-standards, relationship issues, family/cultural norms, social/peer norms, and environmental barriers.
- **Preparation** – The person intends to make the behavior change in the very near future, and is actively getting ready to do so by expressing readiness or developing a plan. This stage is related to self-efficacy and skills.

- **Action** – The person has changed a risky behavior recently, and the change has been in effect for less than six months. This stage is related to emotions and social/peer norms.
- **Maintenance** – The behavior change has been maintained for six months or more, the person is relatively comfortable with the change and has achieved consistency in enacting the new behavior. This stage is related to emotions and social/peer norms.
- **Termination** – Overt behavior will never return, and there is complete confidence that you can cope without fear of relapse.

Usefulness in HIV Prevention

- Fosters diverse approaches to HIV prevention strategies based on age, gender, race/ethnicity, socioeconomic status and other factors (Valdiserri, et al., 1992).
- Assessment is important, and providers need to target only the members at a particular stage or simultaneously design a program that can work with the different stages.

Considerations

- The different types of interventions that may be required may call for a number of different service providers and service settings, and involve collaborations among multiple service organizations to implement the model in a community.
- It may be difficult for a single public health agency to track the progress of diverse communities; intervention responsibilities are best geared to community-based organizations serving particular target groups.

Program Application

A program using the Stages of Change model can determine what "stage" an individual is in and then intervene in ways that are appropriate for that particular stage. Assessment might include questions like:

- Is a person aware of negative effects of a particular behavior?
- Do they perceive themselves to be at risk?
- Is s/he thinking about changing that behavior?
- What do they feel may be negative for them if they try to make a change?
- If someone is preparing to change, what are the steps they are taking to make it happen?
- Do they feel they have the skills to put a condom on correctly or negotiate safer sex with their partner?
- What problems are being encountered as people try to maintain behavior change?

Additional Information:
The following sources may be useful in learning more about the Transtheoretical (Stages of Change) Model.

Baranowski, T. (1990). Reciprocal determinism at the stages of behavior change: An integration of community, personal and behavioral perspectives. *International Quarterly of Community Health Education*, 10, 297-327.

Prochaska, J.O. and DiClemente, C.C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology,* 51, 390-395.

Prochaska, J.O. and DiClemente, C.C. (1986). Toward a comprehensive model of change. In Miller, W.R. and Heather, N. (Eds.), *Treating addictive behaviors* (pp.3-27). New York: Plenum.

Prochaska, J.O., DiClemente, C.C., Norcross, J.C. (1992). In search of how people change. *American Psychologist.* 47, 1102-1114.

Diffusion of Innovations Theory (Rogers)

Overview and Application to HIV Prevention
Diffusion refers to the process by which a new idea or practice (**innovation**) is circulated and accepted among members of a group or population over time. Exposure, which involves one's social network, will help to determine the rate at which various people adopt a new idea or a new behavior. Diffusion theory is based on the following five concepts:

- **Communication channels exist** for the dispersal of the innovation (**social networks**). These can be word of mouth, telephone, Internet, newspapers, newsletters, street sheets, and role model stories. The system for diffusing the innovation can be centralized (i.e., transferred from experts from the top down) or decentralized (i.e., transferred through dialogue between source and target group).
- **Time and process is required** for the message to reach people.
- **Opinion leaders** (highly visible, trusted, respected people, who either live in the community or are available through the media) **can assist** in the diffusion of the innovation ~ **social influence**. They can be employed to communicate new information and they are most effective when their specific role is determined with the target audience in mind. They may live in the community or be accessible through the media.
- The characteristics of the person or medium communicating the innovation, the "**change agent**" will influence the success of the diffusion.
- The innovation must be compatible with the existing values, experiences, and needs of the target group's social system (Dearing et al., 1994).

Opinion leaders may not be as effective as peer dialogue for disseminating information to unique population groups. A decentralized approach should be used for members of marginalized groups, and the change agent within this decentralized approach ought to be a member of the group.

Usefulness in HIV Prevention

- If the core concepts are appropriately adapted, diffusion theory can be used to develop effective interventions for the gay community and injection drug users (Dearing et al., 1994).
- Can be utilized as a framework to reach communities of color.
- Takes into consideration the relationship between cultural influence and behavior change.

Considerations

- Since HIV prevention interventions require addressing taboo topics such as sexual and substance use behaviors, communication channels may be restricted and other barriers to dispersing prevention messages are presented.
- Prevention innovations are generally less likely to be accepted because people may deny they are at risk, do not believe that the proposed behavior change (condom or clean needle use) will actually protect them, or feel that the cost of changing their behavior is greater than the benefit of avoiding possible infection (Dearing et al., 1994).

Program Application

A program using the Diffusion of Innovations approach might use a needs assessment to investigate:

- What are the most effective means, within the target population, to get a message out?
- Who are the community leaders or key representatives who can disseminate the program message?
- What kinds of social networks exist in the community?
- Based on the nature of the target group, and on the existing social network links, which people may be particularly hard to reach?

Additional Information:

The following source may be useful in learning more about the Diffusion of Innovations Theory.

Rogers, E.M. (1983). *Diffusion of Innovations.* Third Edition. New York, NY: The Free Press.

AIDS Risk Reduction Model (Catania, Kegeles & Coates)

Overview and Application to HIV Prevention

This model of behavior change is based on three stages:

- **Labeling** - a person must consciously identify a behavior as risky before they will consider any change;
- **Commitment** - a person must make a commitment to reduce the behavior; and
- **Enactment** - a person must take action to remove or reduce any barriers to the desired change and then actually make the change.

Factors influencing movement between these stages include fear/anxiety and social norms. People may move among the stages in any order.

Usefulness in HIV Prevention

- Research on condom use among heterosexuals (Cantania et al., 1994) found evidence that the three stages are linked to commitment to use condoms and concluded that it can be an accurate model for understanding the behavior change process.

Considerations

- It does not address the personal beliefs and social norms that are important determinants of whether people will achieve the goals of the individual stages and whether they will move from one stage to the next.

Program Application

A program using the AIDS Risk Reduction Model might design a needs assessment to include questions such as:

- Is a person aware of negative effects of a particular behavior?
- Do they perceive themselves to be at risk?
- Is s/he thinking about changing that behavior?
- If someone is preparing to change, what are the steps they are taking to make it happen?
- Do they feel they have the skills to put a condom on correctly or negotiate safer sex with their partner?
- What barriers are being encountered as people try to maintain behavior change?
- What action must they take to make the change?

Additional Information:

The following sources may be useful in learning more about the AIDS Risk Reduction Model.

Catania, J.A., Kegeles, S.M., Coates, T.J. (1990). Toward an understanding of risk behavior: An AIDS risk reduction model. *Health Education Quarterly,* 17, 53-72.

Longshore, D., M. D. Anglin, and S-C Hsieh. (1997). Intended sex with fewer partners: An empirical test of the AIDS risk reduction model among injection drug users. *Journal of Applied Social Psychology,* 27(3), 187-208.

Empowerment Theory (Wallerstein and Bernstein)

Overview and Application to HIV Prevention

Empowerment Theory is based on Paulo Freire's ideas of Popular Education. It is based on the premise that groups of people change through a process of coming together to share experiences, understanding social influences, and collectively developing solutions to problems. The communities own perspectives, concerns and desires are essential to the planning process. An HIV prevention program designed from this model must emerge from the community for which it is being developed. Key components are:

- Identifying targets for change at the individual and group level.
- Participatory education through listening, participatory dialogue, and support for action. The program planner assists community members in developing their own curriculum, and provides direction and awareness regarding HIV prevention while remaining non-judgmental and non-dictatorial.
- Focus Groups and key informants should be used during planning and implementation of the intervention. There is consensus building and planners should function as facilitators.

Usefulness in HIV Prevention

- Can be utilized to reach communities of color and/or high-risk populations.
- The theory takes into consideration the relationship between cultural influence and behavior change.

Considerations

- Little is formally known about its effectiveness. However, given its applicability to increasing self-esteem and providing support, it can be projected to have at least a certain degree of success. As with theory in general, though, it is recommended that Empowerment Theory be considered as one of several components of a strong intervention program.

Program Application

A program using Empowerment Theory would assess:

- What people in the target population or community are concerned about, as well as other issues in the community in addition to the ones that planners are dealing with.
- Do people have a history of coming together to work on issues of mutual concern?
- What is the level of awareness regarding structural barriers to change?
- What do people in the community know about HIV?

Additional Information:
The following sources may be useful in learning more about the Empowerment Theory.

Wallerstein, N. and Berstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. *Health Education Quarterly*, 15(4), 379-394.

Wallerstein N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. *American Journal of Health Promotion,* 6, 197-205.

Theory of Gender and Power (Connel)

Overview and Application to HIV Prevention

The premise of the Theory of Gender and Power is that social influences compromise disadvantaged women's health and autonomy, which can significantly impact their ability to change some behaviors. It focuses on the relationship between two people. Key points:

- **Division of Labor** includes issues of childcare, distinctions between paid and unpaid work, and salary inequities between the sexes. This deals with **relationship issues** and **environmental barriers**.
- **Division of Power** recognizes the power imbalances in heterosexual relationships that contribute to men's authority, control, and coercion over women – **Social Influence**.
- **Cathexis** refers to society's gender approved norms and expectations for appropriate sexual behaviors – **Social Norms**.

Usefulness in HIV Prevention

- Utilized to reach women.
- Useful in understanding additional co-factors related to women at-risk when designing interventions.
- Takes into account patriarchal influence and behavior change.

Considerations

- Little is formally known about its effectiveness. However, given its applicability to increasing self-esteem and providing support, it can be projected to have at least a certain degree of success. As with theory in general, though, it is recommended that Gender and Power Theory be considered as one of several components of a strong intervention program.

Program Application

A program using the Theory of Gender and Power might design a needs assessment to include questions such as:

- Who makes decisions in your relationship?
- Who earns the money; who takes care of the children?
- Do you ever have sex with your partner when you don't want to?

- Do you ever have sex with others when you don't want to? What are the circumstances?
- Have you ever had sex because you needed money, drugs, etc?
- Is it okay for a woman to control what happens during sex?
- Is it okay for a woman to talk about her sexual feelings?

Additional Information:
The following source may be useful in learning more about the Theory of Gender and Power.

Wingood, G.M., DiClemente, R.J. (1992). Application of the theory of gender and power to examine HIV-related exposure, risk factors, and effective intervention for women. *Health Education & Behavior,* Volume 27, Issue 5, October.

Social Networks/Social Support Theory (Minkler)

Overview and Application to HIV Prevention

Social networks and social support theories are based on the concept that social ties improve health and well-being (Minkler, 1985). Social networks and social support are related, though distinct, concepts. Social networks are the chains of social ties that link an individual to others. Social support is the positive emotional and practical products that people derive from their social networks. Both are required, as some social networks may not encourage safe or healthy behaviors. There are several components that determine variability among social networks and their importance to health outcomes:

- **Density and complexity**, or the degree of intimacy and communication among members of a network;
- **Size**, or the number of people in a network;
- **Equality**, or the degree to which supports and obligations are shared among members;
- **Geography**, or how close to each other network members live;
- **Homogeneity**, or the degree of demographic similarity among network members; and
- **Accessibility**, or the ability of network members to contact each other (Berkman, 1984).

Usefulness in HIV Prevention

- Helpful in reaching marginalized groups through peer led HIV interventions
- Applies to socially supportive systems and programs such as street outreach, day programs, group/individual counseling, peer-led interventions and case management.

- Can be used to link people to new social contacts (e.g., through peer or other HIV education groups) that may become new sources of advice, services and information for them.

Considerations

- It is difficult to assess and evaluate the effects of social support and its relationship to health interventions.

Program Application

A program using Social Networks/Social Support Theory might design a needs assessment to determine:

- The type and quality of the person's social network.
- The person's sense of belonging, feelings of worth and of self esteem.
- The extent of the person's links to nurturing social ties.
- Whether a person's primary social network and source of social support positively influences their HIV risk behavior.

Additional Information:

The following sources may be useful in learning more about the Social Influence Models.

Fisher, J.D. (1988). Possible effects of reference group based social influence on AIDS-risk behaviors and AIDS. American Psychologist, November, 914-920.

McGuire, W., & Papageoris, D. (1961). The relative efficacy of various types of prior belief-defense immunity to persuasion. *Journal of Abnormal Social Psychology*, 62, 237-337.

Minkler, M. (1985). Building supportive ties and sense of community among the inner city elderly: the Tenderloin Senior Outreach Project. *Health Education Quarterly,* 12, 303-314.

Harm Reduction Theory

Overview and Application to HIV Prevention

Harm Reduction Theory evolved from substance abuse treatment. It accepts that while harmful behaviors exist, the main goal is to reduce the negative effects of those behaviors. Harm Reduction examines behaviors and attitudes of the individual to offers ways to decrease the negative consequences of the targeted behavior. Basic principles include:

- Acceptance of the existence of harmful behaviors and working towards minimizing the harmful effects.

- Belief that a continuum of behaviors exists and some behaviors are clearly safer than others.
- Belief that a successful intervention is based on the quality of individual and community life and well-being.
- A non-judgmental, non-coercive provision of services and resources.
- Ensuring that the targeted population has a real voice in the creation of programs and policies designed to serve them.
- Seeking to empower clients.
- Recognizing that poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect people's vulnerability to, and capacity for, effectively dealing with harm.
- Not attempting to minimize or ignore the real harm and danger associated with certain behaviors.

Usefulness in HIV Prevention

- Fosters diverse approaches to HIV prevention strategies based on age, gender, sexual orientation, race/ethnicity, socioeconomic status, drug use, and other factors.
- A strength of this theory is that it incorporates acceptance of all social aspects of human behavior.

Considerations

There is no clear definition of, or method for, implementing Harm Reduction because Harm Reduction dictates that interventions be designed to serve specific individual and community needs.

Program Application

A program using Harm Reduction Theory might design a needs assessment to include questions such as:

- What do you feel are some of the things that you do that put you at risk?
- What would you want to change to reduce your risk?
- What things do you need to assist you in reducing your risk?
- How could we help you achieve your goal?

Additional Information:

The following sources may be useful in learning more about the Harm Reduction Theory.

Brettle, R.P. (1991). HIV and harm reduction for injection drug users. *AIDS*. 5, 125-136.

Marlatt, G. A. and Tapert, S. F. Harm reduction: Reducing the risks of addictive behaviors. In J.S. Baer, G. A. Marlatt & R.J. McMahon (Eds.), *Addictive behaviors across the lifespan: Prevention, treatment, and policy issues.* Newbury Park, CA: Sage Publications.

Walch, S.E., Prejean, J. (2001). Reducing HIV risk from compulsive sexual behavior using cognitive behavioral therapy within a harm reduction framework: A case example. *Sexual Addiction & Compulsivity,* 8(2), 113-128.

The website for the Harm Reduction Coalition also provides helpful information (http://www.harmreduction.org/index.html)

Social Marketing Theory (McQueen)

Overview and Application to HIV Prevention

Social marketing as a behavior theory applies the concepts of traditional marketing to the "sale" or promotion of healthy behaviors (i.e., the product) to the target group (i.e., the consumer). A particular behavior is made socially desirable by linking it to something that is valued by the targeted community. It is successful when it involves the active participation of both the providers and the recipients of the information or services. The major components of the theory include:

- A market plan
- A carefully designed message
- Use of mass media
- Consensus building
- Appropriate packaging (Coates and Greenblatt, 1990)

Usefulness in HIV Prevention

- Useful in changing community norms.
- Can be effective with those who need new information to change behavior, or who want to change their behavior but have not.
- Can be accessible to those who are difficult to reach through traditional prevention channels.

Considerations

- May not be appropriate for those engaging in highest risk behavior.
- May be unsuccessful with those who are isolated and to not see themselves in relation to the campaign.

Program Application

A program using the Social Marketing Theory might design a needs assessment to include questions such as:

- What community norm is the most important to address for this population?
- What types of media does the target group most frequently use or see?
- What cultural considerations need to be incorporated into those messages?
- What method of delivery would be most successful in reaching the target audience?

Additional Information:
The following sources may be useful in learning more about the Social Marketing Theory.

Coates, T. and Greenblatt, R. 1990. Behavioral change using interventions at the community level. In K. Holmes, P. Mardrh, P.F. Sparling, and P.J. Wilson (eds.), *Sexually Transmitted Diseases* (2nd ed.). pp 1075-1080. New York: McGraw-Hill.

McQueen, D. (Ed.) (1991). *Health Education Research: Theory and Practice,* 6, 37-255.

Additional Sources of Information on Behavioral Science Theories

The following websites are also excellent sources of information on theories and interventions:
Centers for Disease Control and Prevention (http://www.cdc.gov/)

University of San Francisco, Center for AIDS Prevention Studies (CAPS) (http://www.caps.ucsf.edu/)

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Some of the material in this section was modified and adapted from the following sources:

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Centers for Disease Control and Prevention (CDC). (1999). *Evaluation Guidance*.

Coloradans Working Together Preventing HIV/AIDS 2001-2006 (2003). Colorado Core Planning Group (CPG).

Iowa Comprehensive HIV Prevention Plan 2001-2003 (2001). Iowa HIV Prevention Community Planning Group.

Kelley, J. (1995). *Changing HIV risk behavior: Practical strategies.* Guilford Press, New York.

Herlocher, T., Hoff, C., and DeCarlo, P. University of California, San Francisco (UCSF). (1995). *Can theory help in HIV prevention?*. HIV prevention: Looking back, looking ahead. A project of the Center for AIDS Prevention Studies (CAPS), University of California, San Francisco, and The Harvard Institute.

Prevention Training Centers, CDC. (October, 1997) *"Bridging Theory & Practice" Applying Behavioral Theory to STD/HIV Prevention,* Participants course manual.

Wilkerson, D.E. (1996, October). Developing effective theory-based HIV prevention interventions. A workshop presented at the 1996 National Skills Building Conference, Washington D.C.

Additional Source Citations

Abraham C. and Sheeran P. (1994). Modeling and modifying young heterosexuals' HIV-preventive behavior: A review of theories, findings and educational implications. *Patient Education and Counseling,* 23:173-186.

Basen-Enquist, K. (1994). Evaluation of a theory-based HIV prevention intervention for college students. *AIDS Education and Prevention,* 6(5):412-424.

Berkman, L. F. (1984). Assessing the physical health effects of social networks and social support. *Annual Review of Public Health* 5:413-32.

Catania, J.A., Coates, T.J., and Kegeles, S. (1994). A test of the AIDS risk reduction model: psychosocial correlates of condom use in the AMEN Cohort Study. *Health Psychology,* 13(6), 548-555.

Coates, T. and Greenblatt, R. (1990). Behavioral change using interventions at the community level. In K. Holmes, P. Mardrh, P.F. Sparling, and P.J. Wilson (Eds.), Sexually Transmitted Diseases (2nd ed.). pp 1075-1080. New York: McGraw-Hill.

Dearing, J.W., Meyer, G., Rogers, E.M. (1994). Diffusion theory and HIV risk behavior change in preventing AIDS: Theories and methods of behavioral interventions. In R.J. DiClemente and J.L. Peterson (Eds.), Plenum Publishing Corporation: New York.

Emmons, C.A., Joseph, J.G., Kessler, R.C., Wortman, C.B., Montgomery, S.B., and Ostrow, D.G. (1986). Psychosocial predictors of reported behavior change in homosexual men at risk for AIDS. *Health Education Quarterly,* 13:331-345.

Fisher, J.D. and Fisher, W.A. (1992). Changing AIDS-risk behavior. *Psychological Bulletin,* 111:455-474.

Hingson, R.W., Strunin, L., Berlin, B.M., Heeren, T. (1990). Beliefs about AIDS, use of alcohol and drug and unprotected sex among Massachusetts adolescents. *Journal of the American Medical Association,* 266(17):2419-2429.

Holtgrave, D.R., Qualls, N.L., Curran, J.W., Valdiserri, R.O., Guinan, M.E. & Parra, W.C. (1995). An overview of the effectiveness and efficiency of HIV prevention programs. *Public Health Reports,* 110(2):134-146.

McKusick, L., Coates, T.J., Morin, S.F., Pollack, L., Hoff, C. (1990). Longitudinal predictors of reductions in unprotected anal intercourse among gay men in San Francisco: The AIDS behavioral research project. *American Journal of Public Health*. 80(8):978-983.

McLeroy, K.R., Steckler, A.B., Simmons-Morton, B., Goodman, R.M., Gottleib, N. and Burdine, J.N. (1993). Social science theory in health education: Time for a new model?. *Health Education Research, editorial.* September, 1993.

Minkler, (1985). Building supportive ties and sense of community among the inner city elderly: The tenderloin senior outreach project. *Health Education Quarterly,* 12, 303-314.

Petosa, R. and Jackson, K. (1991). Using the health belief model to predict safer sex intentions among adolescents. *Health Education Quarterly.* 18(4):463-476.

Valdiserri, R.O., West G.R., Moore, M. et al. (1992). Structuring HIV prevention service delivery systems on the basis of social science theory. *Journal of Community Health,* 17(5):259-269.

Chapter 7
POPULATIONS REQUIRING ADDITIONAL CONSIDERATIONS

For HIV prevention interventions to be successful, they must be tailored to meet the specific needs of those at risk. Some populations require distinct HIV prevention strategies and cultural competencies on the part of HIV prevention educators. These populations include but are not limited to:

- People who are deaf or hard of hearing
- People who have developmental disabilities
- People who are homeless
- People who are incarcerated
- People with a mental health diagnosis
- Racial and ethnic minority populations
- Transgendered persons
- Youth

Although information about the behaviors that put each of these populations at risk for HIV is included in the information found in Chapter 4, this section offers supplemental information specific to the abovementioned groups. It is important to recognize that the information included here can augment, but not substitute, the actual cultural competence required to work effectively with these various populations.

PEOPLE WHO ARE DEAF OR HARD OF HEARING

The deaf community is a socio-linguistic and culturally autonomous community of individuals who have American Sign Language (ASL) as their primary language. The assumption is that 8.6% of the population has a hearing loss and 10% of that population, has a severe to profound loss. In Maine this would mean that there are approximately 10,900 people with a severe to profound hearing loss based on the 2000 Census population information. Many of these people are isolated from hearing communities due to linguistic and cultural distinctions. Deaf people are not easily reached by HIV prevention interventions, since interventions are typically designed by hearing persons, for hearing populations, in a hearing culture.

A study of comparing deaf and hard of hearing people to hearing people (Woodroffe et al., 1998) revealed that deaf people's attitudes about HIV transmission often differ from the attitudes of hearing people. Deaf people in the study were more likely to believe that they were not at risk for HIV than hearing people, and were less likely to modify their risky behaviors. The study found that, like many other minority populations, deaf people have less access to culturally competent HIV prevention messages, and are more distrustful of these messages than the general population.

Likewise, substance abuse is more prevalent in the deaf community, which may put this population at increased risk for HIV transmission. For example, within the hearing community 1 in 10 people have a substance abuse problem; within the Deaf Community, 1 in 7 people has a substance abuse problem (Peinkoffer, 1994). Additionally, deaf individuals may be at increased risk because of histories of sexual abuse; data indicates that this population is twice as likely as hearing people to be victims of sexual abuse (Sullivan, 1998).

Considerations for HIV Prevention:

- It is crucial that interventions targeting this population use methods of communication appropriate for people who are deaf/hard of hearing. For this reason, interventions must be delivered by those fluent in American Sign Language (ASL).
- Because of fundamental differences between English and ASL, written materials designed in English for hearing people are often not easily understood by those who are deaf/hard of hearing. Any written materials used for HIV prevention should use written ASL and be specifically designed for this population. Print materials should have a minimal English requirement and be very visual and graphic in nature.
- Because of the cultural autonomy of the deaf community, effective interventions must be delivered by peers, or by those with intimate knowledge of ASL and the deaf community.
- Certified ASL interpreters should be used for instances where hearing people need to communicate with those who are deaf/hard of hearing (such as during Counseling and Testing). Interpreters may need special training to provide HIV/AIDS services. The importance of confidentiality should be affirmed with both the client and the interpreter.

Resources Providing More Information about HIV Prevention for this Population:

Maine Center on Deafness, 68 Bishop Street, Suite 3, Portland ME 04103; (207) 797-7657 (voice/TTY), 1-800-639-3884 (voice/TTY), (207) 797-9791 (FAX)

Center for AIDS Prevention Studies at the University of California San Francisco, “Fact Sheet 36E: What Are Deaf Persons' HIV Prevention Needs?” available on the web at: http://www.caps.ucsf.edu/capsweb/

Deaf Queer Resource Center (website): www.deafqueer.org

PEOPLE WITH DEVELOPMENTAL DISABILITIES

According to the CDC (MMWR, January 26, 1996) in 1993 the prevalence rate of persons with mental retardation (intellectual disabilities) in the Maine was 6.9% per 1000 population for people ages 6-64 years. It is estimated that there are seven to eight million Americans of all ages who experience mental retardation or intellectual disabilities. Intellectual disabilities affect about one in ten families in the USA (The Presidents Committee for People with Intellectual Disabilities Fact Sheet, 2003). Nationally the Administration on Developmental Disabilities estimates that there are four million people with developmental disabilities in the US (ADD Fact Sheet, 2002). Developmental disabilities are severe, chronic disabilities attributable to mental and/or physical impairment, which manifest before age 22 and are likely to continue indefinitely.

Unfortunately, there is a lack of information available about how people with developmental disabilities are affected by HIV/AIDS. Some studies indicate that this population may be at increased risk for HIV transmission, and may be difficult to reach through traditional HIV prevention efforts.

A primary issue of concern is that people with mental retardation are particularly vulnerable to victimization through sexual abuse. Some studies estimate that more than 90% of people with developmental disabilities will experience sexual abuse at some point in their lives (Valenti-Hein et al., 1995). In addition, some people with mental retardation may have difficulty controlling sexual feelings and desires, making them more vulnerable to sexual coercion and risky behaviors (McCarthy et al., 1993).

Frank discussions about sexual behavior may not regularly occur for many members of this population. Traditionally family members and caregivers have treated people with mental retardation as children, creating strong taboos and prohibitions around sexual behavior. For this reason, both people with mental retardation and their caregivers may be reluctant to discuss sex and sexuality, making HIV prevention education difficult or impossible (Christensen, 1993). In addition, it is likely that this population lacks access to public health messages in general, including HIV prevention resources (McCarthy et al., 1993).

Finally, because of frequent staff turnover, it is often difficult to train direct care personnel to provide one-to-one HIV prevention interventions to this population. HIV prevention efforts need to be integrated into larger care models for this population (Walkup et al., 1999).

Considerations for HIV Prevention:

- Care providers should acknowledge that sexual activity occurs among this population, and encourage frank discussions about sexual feelings and sexual activity. Additionally, caregivers and family members should be <u>discouraged</u> from treating adults with mental retardation like children.

- Sexual abuse and coercion should be addressed in an open, safe and supportive fashion. Members of this population should be educated to recognize abusive situations and help prevent their occurrence.
- It is crucial that interventions targeting this population be clear and understandable. Some have suggested that photographs may be an appropriate method for reaching this population (Christensen, 1993). In addition, it is often necessary to precede HIV education with more basic discussions of sex and sexuality. Concrete practice with condoms and role-playing may also be helpful.

Resources Providing More Information about HIV Prevention for this Population:

The Arc of the United States, National Headquarters Office; 1010 Wayne Street, Suite 650; Silver Spring, MD 20910; phone: (301) 565-3842; fax: (301) 565-5342; world wide web: http://TheArc.org

The American Association on Mental Retardation; 444 North Capitol Street, NW, Suite 846; Washington, D.C. 20001; phone: (800) 424-3688; fax (202) 387-2193; world wide web: http://www.aamr.org

Maine State Department of Behavioral and Developmental Services, Mental Retardation Services, web: http://www.maine.gov/bds/mrservices/MRindex.htm

PEOPLE WHO ARE HOMELESS

We have limited information about the number of homeless people living in Maine, and the number of homeless people living with HIV. Information about homelessness is not collected during AIDS case reporting. However, reports of positive HIV tests in Maine do include questions about homelessness. During 2003, three people (6%) of 55 people newly diagnosed with HIV in Maine were homeless at the time of their diagnosis (Maine Bureau of Health, 2004).

Homeless people may be at increased risk for HIV, since homelessness may be associated with at-risk behaviors including injection drug use, sex with injection drug users and survival sex. Homeless people also may be affected by chronic mental illness (St Lawrence et al., 1995).

People living with HIV may become homeless because of the high cost of medical care. One study estimated that 36% of people with AIDS had been homeless at some point since learning that they had HIV or AIDS (Robbins and Nelson, 1996).

Apart from local Maine data, national studies (often with an urban focus) have shown that individuals living on the street may be at extremely high risk for HIV infection. One

study (Smereck and Hockman, 1998) discovered HIV seroprevalence rates of up to 19% for this population. Those homeless people who injected drugs, had multiple sex partners, or came from racial minority groups had even higher rates of HIV prevalence.

Considerations for HIV Prevention:

- People who provide services to the homeless should be trained about HIV, STD's and hepatitis prevention and referrals. Appropriate HIV prevention education services, including HIV counseling and testing and HIV prevention case management, should be integrated into existing services for this population.
- Appropriate prevention materials, including condoms, dental dam, lubricant etc. should be distributed in locations accessible to this population, such as shelters and soup kitchens.
- Group level interventions in shelters that are integrated into other regular shelter activities may be an effective way to promote HIV risk reduction in this population.

Resources Providing More Information about HIV Prevention for this Population:

Center for AIDS Prevention Studies at the University of California San Francisco, "Fact Sheet 16E: What are Homeless People's HIV Prevention Needs?" available on the web at: http://www.caps.ucsf.edu/capsweb/

National Coalition for the Homeless, 1012 Fourteenth Street, NW, #600, Washington, DC 20005-3471; phone: (202) 737-6444; fax: (202) 737-6445; email: info@nationalhomeless.org

PEOPLE WHO ARE INCARCERATED*

The prevalence of infectious diseases such as HIV/AIDS, hepatitis C and Tuberculosis infection is on average 4 to 10 times greater among inmates than the general population (Davis, 2002). The identified number of HIV+ inmates and juvenile residents under the jurisdiction of the State Department of Corrections is relatively low, usually between 6-10 people, with an average population of 2,120. This number may be low due to such factors as: voluntary versus mandatory testing policies, hesitancy of prisoners to be tested due to concerns about medical confidentiality, fear of HIV status impacting correctional opportunities that may be available (i.e. housing and job assignments) and concerns about safety if an inmate's or resident's HIV+ status is discovered by other inmates or residents.

Increased efforts to encourage testing and assure inmates and residents about confidentiality are needed. Behaviors that are associated with increased risk for infectious diseases such as tattooing, unprotected sex and drug use are common

behaviors among incarcerated populations. Prevention and education programs need to be designed to reach this population. This can be achieved most successfully by collaborative efforts between correctional staff, medical staff, public health organizations and inmates or residents. The Department of Corrections implemented a Hepatitis C treatment program in November 2003. The initiation of this program may help to encourage testing and decrease risk behaviors.

A contracted provider, Correctional Medical Services (CMS), currently provides medical services for the State Department of Corrections. During an inmate's period of incarceration CMS is responsible to provide HIV counseling and testing, prevention and educations services and appropriate medical management. Support services and case management during incarceration are available to inmates and residents from correctional social work and mental health staff and through collaborations with community based HIV/AIDS agencies or programs.

A critical case management component for all inmates or residents is the transition planning that takes place prior to release. This is especially true for HIV+ inmates or residents. In addition to the transition plan which typically might include housing, financial support, employment, family reintegration and counseling services it is imperative that community based case management and medical services are secured prior to release. Good transition planning enhances continuity of care and increases inmates or residents chances of being successful at staying out of the correctional system.

Considerations for HIV Prevention:

- Collaboration between inmates, corrections administrators, corrections staff, and public health organizations needs to occur in order to promote HIV prevention in prisons.
- Prison staff should be trained about HIV prevention and sensitized to the needs of HIV+ inmates.
- Appropriate HIV prevention education services, including HIV counseling and testing and HIV prevention case management, should be offered to prisoners.
- Coordinated discharge planning, aftercare and follow-up should be provided to inmates released from jails and prisons.
- Inmates should be trained to serve as peer HIV-prevention educators and advocates.

***** The CPG wishes to thank Kathy Plante, Health Planner for the Department of Corrections, for some of the information included in this section.

Resources Providing More Information about HIV Prevention for this Population:

Center for AIDS Prevention Studies at the University of California San Francisco, "Fact Sheet 13EB: What is the Role of Prisons in HIV, Hepatitis, STD and TB Prevention?" available on the web at: http://www.caps.ucsf.edu/capsweb/

Maine Department of Corrections, State House Station 111, Augusta, ME. 04333; phone: (207) 287-4360

Human Rights Watch, 350 Fifth Avenue, 34th floor, New York, NY 10118; phone: (212) 290-4700; fax: (212) 736-1300; email: hrwnyc@hrw.org

CURE National, P.O. Box 2310, Washington, DC 20013; phone: (202) 789-2126; fax: (413) 845-9787; web: http://www.curenational.org

PEOPLE WITH MENTAL ILLNESS*

Nearly 35 thousand of Maine's one million two-hundred thousand residents have a severe mental illness (U.S. Census 2000; U.S. Center for Mental Health Services). In the year 2000, the estimated number of people age 18 or older with a serious mental disorder living in Maine (excluding homeless people or people in institutions) was 26,000 (SAMHSA National Mental Health Information Center). In the year 2000, the estimated number of children and adolescents in Maine with a serious mental disorder was 1,866,112. Of this number over 9,000 were children. An estimated 17.6 percent of those affected live in poverty (SAMHSA National Mental Health Information Center). There is little evidence about the number of people in Maine who have both a mental illness and are also living with HIV, although 7% of those who tested positive in 2003 has some form of mental illness (Maine BOH, 2004).

Individuals living with mental illness, diagnosed or undiagnosed, may be at increased risk of HIV infection for a number of reasons. Some people with mental illness are easily victimized by others and may have difficulty negotiating safe sexual behaviors. Others have illnesses which, when not in remission, involve impulsivity and risk taking behaviors that could also contribute to increased risk of exposure. When a co-occurring substance use disorder is involved, the risk of exposure increases as intoxication can result in impulsive and unprotected sexual activity or use of IV drugs.

In addition, despite the fact that people with mental illness, including those with serious mental illness, are sexually active, many mental health professionals and caregivers perceive them to be asexual or not sexually active, and don't provide them with appropriate education about HIV.

People with serious mental illness are often living in poverty, in substandard housing and in homeless shelters. Fifty percent (50%) of people with a mental disorder will also

have co-occurring substance abuse and eighty percent (80%) of adolescents with a mental illness will have a co-occurring substance abuse disorder. In addition, many people with mental illness are incarcerated. The 2003 report from the Maine Civil Liberties Union, *Health Status of Maine's Prison Population: Results of a Survey of Inmates Incarcerated by the Maine Department of Corrections,* notes that 38.5% of inmates incarcerated in the Maine Department of Corrections system report that they have a mental illness.

Considerations for HIV Prevention:

- It is important to know that people with mental illness are at increased risk for HIV infection and to provide them with appropriate education about prevention. Because people with mental illness may not hear about HIV in the usual places that prevention materials and education are available, it is important to integrate HIV education into regular mental health and substance abuse treatment.
- Mental health practitioners should be trained about the risks their clients face and the need to include HIV education in their clinical work.
- Social clubs, peer support centers, NAMI support groups, and other places where people with mental illness or their families meet should be approached regarding material dissemination or educational forums.
- Peer education about safe sex would be extremely helpful as would education for family members.
- Training updates and multiple educational forums can also help reach larger numbers of people, and reinforce messages that may be forgotten or difficult to process.

* The CPG wishes to thank Carol Carothers, Executive Director of NAMI Maine, for some of the information included in this section.

Resources Providing More Information about HIV Prevention for this Population:

NASTAD HIV Prevention Fact Sheet: "People with Multiple Diagnoses at Risk for HIV." City of Portland; "Community Plan for Comprehensive Services for Individuals with HIV infection Whose Functioning is Impaired by mental Illness and/or Substance Abuse," 1999

American Psychiatric Association, 1400 K Street N.W., Washington, DC 20005; phone: (888) 357-7924; fax: 202-682-6850; web: www.psych.org

National Institutes for Mental Health, NIMH Public Inquiries, 6001 Executive Boulevard, Rm. 8184, MSC 9663, Bethesda, MD 20892-9663; phone: (301) 443-4513; fax: (301) 443-4279; web: www.nimh.nih.gov

National Alliance for the Mentally Ill (NAMI); Colonial Place Three, 2107 Wilson Blvd., Suite 300, Arlington, VA 22201; phone: 703-524-7600; NAMI Help Line: 1-800-950-NAMI [6264]; web: www.nami.org

NAMI Maine, 1 Bangor Street, Augusta, Maine, 04330, phone: 207-622-5767, web: http://me.nami.org/

RACIAL AND ETHNIC MINORITY GROUPS

Many racial and ethnic populations are at high risk for HIV infection, not because of their race or ethnicity, but because of the risk behaviors in which they engage. As with any population, it's not who you are but what you do that puts you at risk for HIV. It is important to note that while the non-White and Hispanic populations of Maine comprise approximately 3.5% of the state's total population, 17% of HIV diagnoses between 1999 and 2003 were among racial and ethnic minority groups. These groups include African-American/Blacks (11%), Latinos/Hispanics (3%) and Native Americans (3%) (Maine Bureau of Health, 2004). The following section provides basic information on three of Maine's racial and ethnic groups that have been shown to be at increased risk for HIV according the current epidemiological data. It is not meant to be inclusive of all of racial and ethnic groups in Maine, nor provide comprehensive information about the groups that are included.

HIV prevention interventions serving racial/ethnic minority populations need to recognize and address the negative effects of systemic racism and discrimination which underlie health disparities in these populations. Institutionalized racism, cultural interruption and disenfranchisement have had a major impact on these populations resulting in distrust and suspicion of public health efforts, particularly if they are perceived as coming from the White majority. It is therefore recommended that as much as possible, programming should be provided by actual members of the community who can better understand the cultures and customs of the group.

When working with racial and ethnic minority groups, it is crucial that HIV prevention providers demonstrate a thorough understanding of the cultures of the target populations. This may include language, symbols, rituals, and cultural dynamics. Although some general information about different races/ethnicities is provided below, it is beyond the scope of this document to comprehensively address cultural competency for any of the races/ethnicities discussed herein.

Specific considerations for HIV prevention among each of these groups is described in following subsections.

AFRICAN AMERICAN/BLACKS*

According to the 2000 US Census data, there were 6,440 African Americans/Blacks in Maine, an increase of approximately 1,500 people from 1990 Census data. Anecdotal information from CPG members indicates that many people in this population are bi- or tri-racial, and in fact, another 2,793 people in the Census stated that they were Black or African American in combination with one or more of the other races listed. This is a total of 9,553 people or .7% of Maine's total population.

During 2003, 6 (11%) of 55 people newly diagnosed with HIV in Maine were African-American/Black. Likewise 11% of HIV diagnoses between 1999 and 2003 were among this group and one third of these (8 of the 24) were foreign born and likely acquired HIV *before* coming to the US (BOH, 2003 Epi Profile). Nationally, this population comprises 37% of AIDS cases, yet makes up only 13% of the US population (CDC, 2000).

As in the rest of the nation, many African-American/Black people are economically disadvantaged. Existing social networks are largely connected to churches and other organizations including the National Association for the Advancement of Colored People (NAACP).

Considerations for HIV Prevention:

- Because community-based HIV prevention efforts are important to this population, it is essential that Black civic and religious groups understand that HIV in Maine is an issue relevant to their members and community.
- It is essential that HIV prevention be provided by people who either come from the African-American/Black community or who are culturally competent providers.
- HIV prevention efforts should emphasize that being in Maine does not prevent HIV infection and that people in this population may be infected through male-to-male sex, injection drug use and heterosexual sex.
- Media campaigns are needed to provide positive images and messages pertaining to healthy behaviors and risk reduction to counteract the pervasive negative and risk-taking behavior generally portrayed by the media at large.
- Unequal treatment in the justice system has resulted in Black people being disproportionately incarcerated. Providing comprehensive prevention education programs in the corrections systems is therefore recommended.
- Easy access to HIV prevention interventions, including outreach, clinics and other sources of confidential testing and counseling, should be provided. Access could be increased with the provision of childcare and transportation.

- Community-building efforts are important for the many members of this population who have recently relocated to Maine from elsewhere in the United States or from foreign countries.
- HIV prevention messages and testing provided to the immigrant and refugee communities should be provided by peers if at all possible, or by culturally competent providers.
- Needs Assessment data, including behavioral data, about the African American and other Black populations in Maine (including immigrants and refugees) is needed to better understand their HIV prevention needs.

* The CPG wishes to thank Anthony Spotten, Outreach Program Manager of Health 2000 Maine, for some of the information on needs and interventions included in this section.

Resources Providing More Information about HIV Prevention for this Population:

Center for AIDS Prevention Studies at the University of California San Francisco, "Fact Sheet 15ER: What are African-Americans' HIV Prevention Needs?" available on the web at: http://www.caps.ucsf.edu/capsweb/

National Minority AIDS Council (NMAC), 1931 13th Street, N.W., Washington, DC 20009; phone: (202) 483-6622; fax: (202) 483-1135; email: info@nmac.org; web: www.nmac.org

Gay Men of African Descent (GMAD), 103 E. 125th Street, Suite 503, 5th Floor, New York, NY 10035; phone: (212) 414-9344; fax: (212) 414-935; email: gmad@aol.com; web: www.gmad.org

Health 2000, P.O. Box 5166, Portland, ME, phone: (207) 828-2001, fax: (207) 828-4944, email: h2kamezion@aol.com

LATINOS/LATINAS/HISPANICS*

The 2000 US Census data indicates that Hispanic or Latino ethnicity accounts for .7% of the Maine population, or approximately 9,400 people. However, the exact number of people who are Hispanic is not known because of two important complicating factors: lack of accurate data of individuals who may be illegal immigrants, and Hispanic migrant workers who may not be accurately accounted for in Census data. The 2000 Census data shows concentrations of Latinos in five counties of Maine: Cumberland, York, Penobscot, Androscoggin and Kennebec although Latinos are dispersed throughout the State. The Census data shows that the majority of Latinos in Maine are originally from Mexico, Puerto Rico and Cuba while other countries are also represented. Note that within the community, people refer to themselves by their country of origin (Mexican, Puerto Rican, Cuban, Guatemalan etc.) rather than using the terms Hispanic or Latino.

During 2003, 4 (7%) of 55 people newly diagnosed with HIV in Maine were Latino/Hispanic. Likewise 3% of HIV diagnoses between 1999 and 2003 were among this group (BOH, 2004). Nationally, Hispanics account for 17% of all AIDS cases, but make up only 9% of the population. Highest concentrations of HIV+ Hispanic people are located in urban centers in the northeastern US, including New York and Boston (CDC, 2000).

Considerations for HIV Prevention:

- Greater understanding and respect for Latino cultures will lead to better HIV prevention efforts. Cultural dynamics including *machismo* (an expression of masculinity in males), *familismo* (importance of the family), *simpatia* (importance of polite social norms), and *personalismo* (preference for familiarity in relationships) can all affect the delivery of HIV prevention interventions.
- More behavioral data about the Latino community in Maine is needed to better understand the HIV prevention needs of these people. In particular, more needs to be learned about the needs of the Hispanic migrant farming community. Services for migrant workers are currently being provided by the Maine Migrant Health Program which provides services in Androscoggin, Aroostook and Washington Counties.
- Language-specific barriers need to be addressed; in particular, language-specific literature needs to be provided that is easily understood, including materials that do not require reading skills in English or Spanish.
- Increasing access to HIV prevention interventions and provision of testing out in the community is important. Transportation and childcare during HIV prevention-related activities could also increase access.
- In addition, easy access should be provided to clinics that offer confidential and anonymous HIV testing and counseling by providers fluent in Spanish. Often even Latinos that are comfortable with spoken English are best served in Spanish.
- In Maine over 90% of Latinos are Catholic (Latino Health and Community Service, Inc. 2004), so partnering with the church to provide information could be useful.
- Media using well known Latino leaders to provide prevention messages is also recommended.

* The CPG wishes to thank John Connors, Executive Director of Latino Health and Community Service, Maine, for some of the information on needs and interventions included in this section.

Resources Providing More Information about HIV Prevention for this Population:

National Minority AIDS Council (NMAC), 1931 13th Street, N.W., Washington, DC 20009; phone: (202) 483-6622; fax: (202) 483-1135; email: info@nmac.org; web: www.nmac.org

Center for AIDS Prevention Studies at the University of California San Francisco's "Fact Sheet 17E: What are Latinos' HIV Prevention Needs?" available on the web at: http://www.caps.ucsf.edu/capsweb/

Hispanic AIDS Forum, 184 Fifth Avenue, Fl. 7, New York, NY 10010; phone: (212) 741-9797; web: http://www.hispanicfederation.org/agencies/haf.htm

Latino Health and Community Service, Inc., 169 Ocean Street, Suite 205, South Portland, ME 04106, phone: (207) 347-7359, fax: (207) 347-7228, email: JConn10471@aol.com

NATIVE AMERICANS*

There are five Native American communities in Maine: two Passamaquoddy reservations - Pleasant Point and Indian Township in Washington County, and one Penobscot reservation - Indian Island in Penobscot County. The Aroostook Band of Micmac and the Houlton Band of Maliseet are both located in Aroostook County. There are off-reservation population clusters of Native Americans in the general areas of Portland and Bangor, and in Aroostook and Washington Counties. Native American migrant workers are originally from both the US and Canada. Many Native Americans are mobile, traveling back and forth across the Canadian border. Some of this mobility is due to seasonal employment.

The 2000 US Census indicates that approximately 7,000 Native Americans (.6% of the total population) live in Maine, although anecdotal information provided by CPG members suggests that the actual population may be much higher, between 8,000 to 10,000 people. The US Census shows an additional 6,000 people who said they were Native American in combination with one or more other race.

During 2003, 2 (4%) of 55 people newly diagnosed with HIV in Maine were Native American. Likewise 3% of HIV diagnoses between 1999 and 2003 were among this group (Maine Bureau of Health, 2004), although these figures may be inaccurate because of frequent misclassification of the race of Native Americans by medical providers. Nationally, this population comprises less than 1% of AIDS cases (CDC, 2000).

Considerations for HIV Prevention:

- It is important that any HIV prevention materials be responsive to the particular needs of each tribe in Maine. Ideally, HIV prevention programs should be delivered by Native American providers who can provide culturally-specific services. If non-Native providers deliver services, they must be culturally

competent and recognize that outsiders need to build trust and credibility within the community and that Native culture is more conservative about talking about sexual behavior.

- HIV prevention providers need to be aware of mistrust in the Native population of government-sponsored health initiatives.
- Strict confidentiality is of utmost importance when working in small, closed, tribal communities.
- Support for gay, lesbian, bisexual and transgender Native Americans could include events to bring people in to learn about support groups, or development of an anonymous way for people to communicate such as a website.
- Services should include easy access to affordable and confidential HIV counseling and testing. Messages should emphasize that HIV/AIDS is also a Native American problem. In addition, messages to help make individuals aware of the connections between sexually transmitted diseases, unintended pregnancies, substance use and abuse, and HIV are very important and should be stressed.
- Alternative ways to gather information on the CTR counseling form could be explored with the health department in order to be more sensitive to cultural norms.
- Messages should include ways of obtaining clean needles (pharmacies and/or needle exchange if one is nearby) and the importance of not sharing needles as there are limited resources for clean needles on the reservations.
- Education and prevention should target the youth through group activities and conferences that are culturally appropriate and led by Native Americans.
- Safer sex supplies should be available at a variety of places in the community.

* The CPG wishes to thank Sharon Tomah, Executive Director of Wabanaki Mental Health, Maine, Roger Paul, Cultural Director, Indian Township Health Center and Georgia Mitchell for some of information on needs and interventions included in this section.

Resources Providing More Information about HIV Prevention for this Population:

National Minority AIDS Council (NMAC), 1931 13th Street, N.W., Washington, DC 20009; phone: (202) 483-6622; fax: (202) 483-1135; email: info@nmac.org; web: www.nmac.org

National Native American AIDS Prevention Center, 436-14th Street, Suite 1020, Oakland, CA 94612; phone: (510) 444-2051; fax: (510) 444-1593; email: information@nnaapc.org; web: www.nnaapc.org

Wabanaki Mental Health Association, 187 Exchange Street, Bangor ME 04401, phone: (207) 990-0605, or e-mail Sharon Tomah at: stomah@wabanaki.org

TRANSGENDERED PERSONS

Transgendered is an umbrella term used to describe all persons who do not to conform to the societal gender norms usually associated with male and female. Such individuals have gender identities, expression or behaviors not traditionally associated with their physical sex at birth. A transsexual is a transgender individual who desires hormonal and genital reassignment. However, not everyone who is transgender wants hormone therapy or surgery to change their physical characteristics. Transgender persons may self-identify as female, male, trans-women or –men, non-operative transsexuals, Gender Queer, M2F or F2M and pre-operative transsexuals among others. It is important to remember that there is a distinction between ones biological sex, ones gender expression, and ones sexual orientation. Transgender individuals may identify as heterosexual, bisexual, pansexual or homosexual.

Considerations for HIV Prevention:

- Pervasive social stigmatization of transgender persons greatly increases HIV risk in this population and results in social marginalization and denial of educational, employment and housing opportunities. This can lead to low self esteem, drug use, and can increase the need for survival sex work. All of these factors can increase HIV risk.
- HIV risk through hormone injection varies due to the availability of hormones and hormone syringes. Needle exchange programs should offer needles for hormone injection such as 22 gauge, 1 inch Intramuscular needles among others.
- Although Maine transgender risk behavioral survey data does not show increased risk in the transgender population, nationally transgender individuals are at risk for HIV infection and male to female (MTF) transgender individuals are at the highest risk of HIV infection.
- When working with this population, acknowledgement and acceptance of a transgender persons expression of their gender identity is very important. Forms should be as inclusive as possible and offer more than just two “genders.” It is important to note that for some individuals gender identity can be fluid and may not remain the same over time. There is a great need for transgender sensitivity training for all public service providers.
- Due to the many and varied needs of transgender individuals, a comprehensive health-based approach is useful. This can be facilitated by training peers to do outreach to the population, providing CTR services and referrals to other needed services.

Resources Providing More Information about HIV Prevention for this Population:

Center for AIDS Prevention Studies at the University of California San Francisco's "Fact Sheet 41E: What are the HIV Prevention Needs of Male-to-Female Transgender Persons (MTFs)" available on the web at: http://www.caps.ucsf.edu/capsweb/

Kammerer, N., Mason, T. et al. (1995). Transgender Health and Social Service Needs in the Context of HIV Risk. In W. Bockting & S. Kirk (Eds.), *Transgender and HIV (pp. 39-57).* Haworth Press, NY.

Bockting, W., Rosser, B.R., & Coleman, E. (1995). Transgender Health and Social Service Needs in the Context of HIV Risk. In W. Bockting & S. Kirk (Eds.), *Transgender and HIV (pp. 39-57).* Haworth Press, NY.

Kenagy, G.P. (2002). HIV among transgendered people. *AIDS Care,* 14(1), 127-135.

Clements-Nolle, K., Marx, R. et al. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health,* 91(6), 915-922.

YOUTH

In the context of this document, the noun "youth" is used to be inclusive of young people who are age 24 and under and who exhibit high-risk behaviors or who are in situations that place them at higher risk for HIV infection.

The CDC estimates that nationwide, about half of the 40,000 HIV infections that occur each year are among those under 25 years of age (CDC, 2000). During 2003, of the 55 people who received a new HIV diagnosis in Maine, 5 (9%) were under 25 years old and 17 (31%) were under 30 (BOH, 2004).

In addition, recent surveys of youth also show the presence of HIV risk behaviors. A 2003 Youth Risk Behavior Survey conducted by the Maine Department of Education revealed that 43**%** of Maine high school students were sexually active. Fifty-eight percent of students who were sexually active in the past three months reported using a condom at the time of last intercourse. Sixty-two percent of males in this group used a condom at last sexual intercourse. Male students who reported same or bi-sexual contact were less apt to have used a condom at last intercourse and more apt to have used alcohol or drugs before last intercourse. One out of ten high school students reported having been forced to have sexual intercourse against their will at some time in their lives. For male high school students who reported same or bi-sexual contact the percent is higher. Youth who are homeless and out-of-school, also report a higher percent of sexual victimization (1999 data). A recent study of homeless and out-of-school youth indicated that, for many, their first sexual experience was non-consensual (Maine Department of Education, 1999).

Typically, adolescence is a period of intense physical, emotional, intellectual and sexual development. As part of development and exploration, young people may experiment with drugs, alcohol and sexual behaviors. In addition, youth often experience social, cultural and peer pressure to become sexually active. At the same, many youth lack access to accurate information about sexual behavior and physical development.

Considerations for HIV Prevention:

- For youth-focused interventions to be effective, youth must be involved as equal partners with equal power in the design, implementation, and evaluation of the intervention. It is clear from the epi-data that young men who have sex with men are at much higher risk for HIV infection in the youth population. They need specific HIV prevention interventions that meet their unique needs.
- HIV prevention should be integrated into all youth services including education and other HIV interventions and services. In particular, youth need access to school-based health clinics with sexual health services in high schools and middle schools.
- Prevention services should allow for HIV risk reduction skills practice in as close to "real" risk situations as possible, and include open, non-judgmental messages and discussions about alcohol/drug use and its connection to sexual behaviors that put one at risk for HIV.
- Youth need access to caring, accepting adults and peers who can share positive HIV prevention messages, skills and harm reduction strategies.
- Youth need access to sex positive, non-judgmental, comprehensive sexuality education, health services and media messages. In addition, there needs to be increased community awareness and acceptance of youth sexual health needs specific to HIV/STDs.
- HIV prevention and testing services should specifically target queer youth, in particular males who have sex with males and lesbian or bisexually-identified females who have sex with males. These services should also target youth who are homeless, out of school, and incarcerated.

Resources Providing More Information about HIV Prevention for this Population:

Center for AIDS Prevention Studies at the University of California San Francisco's "Fact Sheet 9ER: What are Adolescent's HIV Prevention Needs?" available on the web at: http://www.caps.ucsf.edu/capsweb/

OUTRIGHT Chapters in Maine offer support and advocacy for GLBTQ youth. Contact information can be obtained at www.outright.org

Maine Department of Education HIV Prevention Education Program, 23 State House Station, Augusta, ME 04333-0011, phone: (207) 287-5118, web: http://janus.state.me.us/education/hiv/homepage.htm

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